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USHINDI

Overcoming sexual and gender based violence in Eastern Democratic Republic of Congo

ANNUAL REPORT

October 2015 – September 2016

Implemented by IMA World Health with ABA Rule of Law Initiative,
HEAL Africa, Panzi Foundation, and PPSSP

Cooperative Agreement No. # AID-623-A-10-00012-00

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List of Acronyms

ABA/ROLI	American Bar Association/Rule of Law Initiative
AOR	Agreement Officer Representative
BCC	Behavior Change Communication
BCZS	Bureau Centrale Zone de Santé (Health Zone Office)
CBO	Community-Based Organization
CPT	Cognitive Processing Therapy
DPS	Division Provincial Santé (Provincial Ministry of Health)
DRC	Democratic Republic of Congo (aka DR Congo)
ECHO	European Commission's Humanitarian Aid and Civil Protection department
ECP	Emergency Contraceptive Pill
GBV	Gender Based Violence (other forms, i.e. not sexual, of Gender Based Violence)
GBV-AMS	Gender Based Violence Assistance Multi-Sectorial
HEAL Africa	Health, Education, Community Action, Leadership Development
HA	Health Area
HZ	Health Zone
IGA	Income Generating Activities
IMA	Interchurch Medical Assistance (aka IMA World Health)
IMC	International Medical Corps
INLA Project	International Narcotics and Law Enforcement Project
IP	Implementing Partner
KPC	Knowledge, Practice and Coverage Survey
JHU	Johns Hopkins University
M&E	Monitoring and Evaluation
MTE	Mid-Term Evaluation
MOH	Ministry of Health
Noyaux	*Noyaux* Community Care (Community Core Groups)
NGO	Non-Governmental Organization
OPJ	Officier de la Police Judiciaire (court officials)
OSC	Overseas Strategic Consulting, Ltd.
PEP	Post Exposure Prophylaxis
PPR	Performance Plan & Report
PPSSP	Programme de Promotion des Soins de Santé Primaires (Program for the Promotion of Primary Health Care)
RECOPE	Réseau Communautaire de Protection de l'Enfance (Community Network for Child Protection)
SBCC	Social Behavior Change Communication
SGBV	Sexual and Gender Based Violence
SV	Sexual Violence
STI	Sexually Transmissible Infections
ToT	Training of Trainers
UNHAS	UN Humanitarian Air Service
USAID	United States Agency for International Development
Ushindi	We Will Overcome (in Swahili)
UWash	University of Washington
VSLA	Village Savings and Loans Association

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I Executive Summary

A. Overview

The "Overcoming Sexual and Gender Based Violence in Eastern DRC" Ushindi program implements holistic approaches to combat sexual and gender based violence, or SGBV, in the Eastern Democratic Republic of Congo. Its core objectives are in line with USAID's Primary and Intermediate Performance Indicators for SGBV Intervention Programs:

1. Ensure that individuals affected by SGBV gain access to quality timely and age-appropriate care and treatment services;
2. Increase and improve organizational and community capacity to identify and respond effectively to SGBV and to facilitate survivors' recovery;
3. Improve the ability of individuals, community-based organizations, and communities to lead and participate in community-based social integration and economic recovery activities; and
4. Strengthen communities' (individuals & community-based organizations) ability to prevent SGBV.

The project is implemented under the direction of IMA World Health with three implementing partners (HEAL Africa, Panzi Foundation, and PPSSP) and one technical partner (ABA-ROLI). At its inception in 2010, the Ushindi project covered 10 health zones and 108 health areas, with a total beneficiary population of 1,083,071. In year four, coverage was decreased to seven health zones and 72 health areas, with a total beneficiary population of 858,733 people.

In February 2016 the project received a 4.5M, 18-month costed extension to extend services into three new USAID-TOT health zones, modeling best-practices while phasing down activities in the existing seven zones to a level of sustainability. In addition, the project was to document best practices and lessons learned through extensive database research and an on-site impact evaluation by a third-party evaluator.

In collaboration with the Provincial Ministry of Health (DPS) and USAID, three new health zones were selected for start-up in August 2016 and modeling of best practices. This annual report (FY16) covers twelve months of implementation in seven zones and two months of start-up in the three new zones (first month was start-up/training/equipping).

Table 1. **Health Zones and Total Population Assisted**

No.	Health Zone	Partner	No. Health Areas in Zone	Total Zone Population	No. Health Areas Assisted	Total Population Assisted
1	Lolwa	PPSSP	5	42,138	5	42,138
2	Komanda	PPSSP	14	170,063	7	78,501
3	Mutwanga	PPSSP	20	254,582	12	183,973
4	Karisimbi	PPSSP	16	471,569	12	429,674
5	Alimbongo	Heal	17	201,209	12	184,739
6	Lubero	Heal	16	242,912	12	213,548
7	Walikale	Heal	14	156,874	12	144,544
8	Kitutu	Panzi	22	132,155	12	75,233
9	Mwenga	Panzi	17	121,524	12	80,601
10	Katana	Panzi	18	216,248	12	159,247
				2,009,274	108	1,592,198
	*red= three new zones start up August -September 2016					

B. Highlights of Accomplishments for April-September 2016 of this Annual Report

(Please refer to *April 2016 Report* for highlights of first six months (October 2015-March 2016)

1. Start-up of activities in three health zones (training, equipping, and kick-off activities) *(Aug 16)*
2. Procurement of vehicle, motorcycles, laptops, solar and office equipment for new health zones and SBCC materials (tee shirts, vests, hats, posters, etc.) for all health zones *(Jul 16)*
3. Continued capacity building of Ushindi implementing partners (Grants Management, Finance Reporting, Fraud Prevention, Mapping, Operational Research, Data Analysis, etc. *(Apr-Sep 16)*
4. Completed Impact Evaluation by Overseas Strategic Consultants, Ltd. (OSC)/Dr. Lynn Lawry *(Jun 16)*
5. Completed Baseline SGBV Survey by OSC/Dr. Lynn Lawry in three new HZs *(Jul 16)*
6. Completion of training in CPT Collection, Monitoring, and Evaluation Tools by Johns Hopkins University Staff *(Jun 16)*
7. Completion of CPT Intensive Training of Ushindi psychologists by Dr. Debra Kaysen and Dr. Ivan Molton of University of Washington *(Jul 16)*
8. Printing and dissemination of new SBCC material (pamphlets, posters, etc.) *(Jul 16)*
9. Packing and labeling of new stock of PEP kits under the authority of Directorate of Pharmaceuticals (MOH) and distribution to all supported health zones *(Jul 16)*
10. Development of Positive Masculinity Curriculum and training of recipients (local authorities and leaders, youth clubs and *noyaux*) in three new health zones *(Sep 16)*
11. Start-up of environmental activities in supported youth clubs and *noyaux* in 3 new HZs *(Sept 16)*

Kick-off of Ushindi in Walikale Health Zone (Aug 2016)

II Performance Plan and Report (PPR) progress

Table 2. Ushindi project indicators, targets and progress, Oct 2015-Sep 2016

Indicator Title	FY 16 Targets	FY 16 Achievements				Cumulative Results (Oct 2010 - Sept 2016)		
Program Element Indicators by Implementing Mechanism	Target	Male	Female	Total	Progress	Cum. Target	Cum. Achievement	Cum. Progress
PPR1. Number of people benefiting from USG-supported social services (SGBV)	2,200	321	2,743	3,064	139%	27,337	27,857	102%
Dissagregated by SGBV incidence								
People reporting a Sexual Violence Incident[1]	1,232	23	1,567	1,590	129%	18,207	17,128	94%
People reporting other GBV Incident/other vulnerability[2]	968	298	1,176	1,474	152%	9,131	10,729	118%
Total	2,200	321	2,743	3,064	139%	27,337	27,857	102%
Dissagregated by age								
Children (< 18)	880	76	1,013	1,089	124%	10,907	9,887	91%
Adults (>18)	1,320	245	1,730	1,975	150%	16,430	17,970	109%
Total	2,200	321	2,743	3,064	139%	27,337	27,857	102%
Dissagregated by type of service								
People receiving health support	1,232	26	1,437	1,463	119%	18,850	16,193	86%
**Rape survivors receiving PEP Kits*	739	15	763	778	105%	4,167	5,279	127%
**Rape survivors receiving Sexualy transmitted infection treatment*	493	5	491	496	101%	2,893	6,829	236%
**People treated for fistula and vaginal prolapses*	25	0	65	65	264%	150	329	220%
People receiving psychosocial support	2,200	297	2,649	2,945	134%	27,113	27,471	101%
** People recovered from psychosocial trauma relatd to SGBV(60% of assisted)*	1,320	161	1,666	1,827	138%	16,268	14,112	87%
People requesting legal support	880	138	1,078	1,216	138%	12,386	15,634	126%
** People receiving legal support - SGBV*	493	5	585	590	120%	5,130	5,295	103%
**People receiving legal support - GBV*	387	133	493	626	162%	10,280	7,811	76%
Cases taken to court	246	4	324	328	133%	2,040	3,099	152%
**Number of judgements*	62	0	16	16	26%	1,381	468	34%
**Number of mediation achieved*	271	56	236	292	108%	2,775	2,536	91%
*Number of survivors enrolled in VSLA (20% of SGBV survivors recovered from psychological and physicaly healed)	440	0	464	464	105%	8,609	3,805	44%
Other beneficiaries								
People enrolled in 444 VSLA groups for socio-economic reintegration support (133 targeted health clinics x 4 VSLA x 25 members)	13,300	1,615	5,510	7,125	54%	32,611	34,877	107%
**Number of people who have completed VSLA cycle of 12 months(80%)*[3]	10,640	1,615	5,510	7,125	67%	20,960	30,284	144%
**Number of people assisted by social fund (80% of VSLA active members)*[4]	8,512	311	5,175	5,486	64%	18,297	14,705	80%
** Number of people benefiting from youth led environmental projects / 133 targeted HA x 1000)*	133,000	8,000	7,000	15,000	11%	136,783	17,858	13%
Outreach & Public Awareness								
Community leaders engaged in BCC activities (5 leaders x 133 HC)	665	1,618	1,349	2,967	446%	3,802	50,811	1336%
Community members reached by BCC activities(70% of 1,300,000 targeted population)	910,000	54,015	96,363	150,378	17%	1,721,314	1,470,779	85%
School children involved in BCC activities (30% 0f 1,300,000 targeted population)	390,000	16,103	19,605	35,708	9%	537,914	301,763	56%
People in uniforms involved in BCC activities (about 100 by month / HZ)	9,600	303	76	379	4%	15,675	3,720	24%

1Sexual violence is defined as any incident of rape, sexual harassment or forced/early marriage. 2Other incidents of gender based violence include any incidents of psychological/emotional violence, physical harassment and denial of resources or opportunities. Vulnerable persons are cases of fistula or vaginal prolapse. 3Given an error in the calculation of this target in the cooperative agreement, the target has been corrected in this table from 352 to 10,640. 4Given an error in the calculation of this target in the cooperative agreement, the target has been corrected in this table from 282 to 8512. *Though no modifications have been made to the targets set in the cooperative agreement, there is believed to be a miscalculation of the targets for these indicators. Please see explanation below.

Table 2. Ushindi project indicators, targets and progress, Oct 2015-Sep 2016

Indicator Title	FY 16 Targets	FY 16 Achievements				Cumulative Results (Oct 2010 - Sept 2016)		
Program Element Indicators by Implementing Mechanism	Target	Male	Female	Total	Progress	Cum. Target	Cum. Achievement	Cum. Progress
PPR2. Number of service providers trained who serve vulnerable persons								
Health service providers	162	104	29	133	82%	324	713	220%
Psychological counselors on GBV -specific trauma counselling and orientation	145	5	202	207	143%	271	743	274%
Counselors on CPT techniques	20	8	5	13	65%	290	285	98%
ToT of OPJ and Paralegals on DRC -GBV laws and judiciary system	270	129	16	145	54%	540	540	100%
Noyaux members on GBV prevention ownership, sutainability, management and leadership	3,192	759	561	1,320	41%	3,444	1,860	54%
Community leaders on Customary law and DRC - GBV laws and judiciary system	270	160	30	190	70%	540	532	99%
Teachers , school directors and noyaux mentors on Child Protection life skills	270	105	36	141	52%	302	681	225%
Leaders of women's associations on Women leadership, good governance and conflict resolution	270	13	135	148	55%	270	148	55%
Youth clubs leaders on GBV prevention , Peace bulding and safe environnement	532	81	50	131	25%	532	131	25%
Community Supervisor and mobilizer of VSLA	30	34	10	44	147%	60	686	1143%
Community mobilizers on GBV prevention, Gender and climate change	30	20	20	40	133%	30	435	1450%
PPR3. Number of USG-assisted organizations and/or service delivery systems strengthened that serve vulnerable populations: organisations, Health Centers	710			624	88%	1,282	653	51%
Health Centers	133	-	-	108	81%	241	216	90%
CBO, NGO/groups& associations created with Ushindi's support(444 new supported VSLA)	444	-	-	408	92%	908	1,341	148%
Youth clubs engaged in environmental or peacebuilding activities	133	-	-	108	81%	133	108	81%

4. Explanation of Target Variances

As noted above, targets for service provision to survivors were largely met or surpassed. Following are select comments on overall performance and those indicators that exceed or, in particular, have missed their targets.

- **Number of people benefitting from USG-supported social services:** At 139 percent of the target, the Ushindi project exceeded its target for the number of people benefitting from USG-supported social services during FY16. In general, the Ushindi project largely met or surpassed all of its targets related to service provision, while performance on provider training generally lagged behind targets. In preparation for the Ushindi project extension, targets for Fiscal Year 2016 were revised to account for the proposed exit from three to four existing health zones and entry into two to three new health zones. It was anticipated that total health zone coverage during the extension phase would not exceed six health zones. Since October 2015 however, Ushindi has remained functional (at a decreased level of funding) in all original project health zones while extending into three new health zones in August 2016. Considering past demand for services, the decision to sustain project implementation in 10 health zones and the impact of reduced funding, IPs prioritized service provision to survivors and provider training in new health zones. This explains the higher number of persons receiving services and relative decrease in training. In the seven original health zones, IPs provided mentoring or refresher (non-formal) training to some of the projects' previously trained providers. Training of providers in new health zones continues and IMA believes this target will be met.
- **People treated for fistula and vaginal prolapse:** Following trends seen over the duration of the Ushindi project, the number of people treated for fistula and vaginal prolapse far exceeded its

target. This is mainly due to limited access to basic reproductive health services in health zones affected by insecurity and displacement and higher rates of complications from obstructed labor.

- **Number of judgments:** At 26 percent, progress on this indicator is well below target. This is in contrast to a higher than expected number of cases brought to court (328, or 133 percent of target). This can be explained by constraints in the judicial system and the significant delays and amount of time it takes to try cases. The long distances that plaintiffs often have to travel to bring a case, coupled with work and family obligations, often hinder the process as well. IMA is in discussion with ABA about increasing the number of mobile courts in this next reporting period, with supplemental support from a US State Department funded program (INLA Project). Mobile courts not only decrease wait time, reduce case load, and ease the burden of plaintiffs but also provide a public and highly visible venue where perpetrators are tried – a significant deterrent to SGBV as suggested by the recent OSC impact evaluation of Ushindi.
- **Number of people benefiting from youth-led environmental projects:** IMA in collaboration with WWF is creating tree nurseries in select youth clubs in the three new target zones; these will be used as part of a reforestation and income generation project. Due to the cost and time, this activity has been limited to the three new health zones and will serve as a model for a future phase. (The original target was any environmental activity in all health areas.) Early evidence (Sep-Oct 2016) has shown a significant increase in attendance in youth clubs and interest in reforestation from youth and *noyaux* groups alike. Increased participation in youth club settings creates opportunities for enhanced awareness of SGBV and occasions for modeling, mentoring, and other forms of positive behavior change.
- **Other beneficiaries:** The target number of people enrolled in VSLA was based on Ushindi being functional in 133 health areas during this extension period. In actuality the scope of work in the Cooperative Agreement calls for Ushindi to implement in an average of six zones (~72 health areas) while in actuality the project will be operating in 10 health zones (108 health areas). IMA will respect the target of 133 health areas during this extension period. Given the popularity of VLSA, Ushindi is optimistic about reaching this target by the end of FY17.

  When compared to absolute target numbers, annual progress on the number of people who completed a 12-month VSLA cycle (67%) and the number of people assisted by the social fund (64 percent) are low. However, these low percentages are a cascade effect of low initial enrollment. Of the 7,125 who initially enrolled in VSLA, 100 percent completed the 12-month cycle and 77 percent (5,486) were assisted by the social fund. These percentages are close to or exceed the 80 percent objective used in calculating the targets.
- **Community leaders engaged in BCC activities:** The number of community leaders engaged in BCC activities far exceeds 100 percent of the target. The Ushindi project originally planned to engage 665 different community leaders during FY 2016. However, since turnover in community leadership is low, some community leaders end up participating in more than one BCC activity and are counted more than once. IMA, alongside its partners, is currently considering more appropriate ways to count the number of community leaders engaged in order to avoid duplicate counting.
- **Outreach and public awareness:** A comparison of the initial five-year cumulative targets to the FY16 targets reveals that, for FY16, three of four outreach and public awareness targets were overestimated. The previous five-year cumulative target for community members reached by BCC activities was 770,584 or an average of 154,117 per fiscal year (Table 3). Set at 910,000, the FY16 target exceeds not only the average fiscal year target during the first five years but also the cumulative 5-year target. For the purposes of this report, the contractual targets have not been changed but should be corrected in a future iteration of this program.

Table 3. Comparison of FY 2016 target to average annual target between Oct 2010 and Sep 2015

Indicator Title	TARGETS		
Program Element Indicators by Implementing Mechanism	Cum. Target (5 Years)	Avg. Annual Target (5 Years)	FY 16 Target
Outreach & Public Awareness			
Community members reached by BCC activities	770,584	154,117	910,000
School children involved in BCC activities	145,508	29,102	390,000
People in uniforms involved in BCC activities	5,865	1,173	9,600

When FY16 performance in outreach and public awareness is evaluated based on the average annual targets from the first five years of the project, the performance for this reporting period is on track. For instance, of the average annual target of 154,117 community members to be reached by BCC activities, the project reached 150,379 (98 percent) during FY16 (Table 4).

Table 4. FY 2016 program performance for outreach and public awareness compared to Phase 1 average annual target

Indicator Title	Phase 1 Average Annual Target	FY 16 Achievements			
Program Element Indicators by Implementing Mechanism		Male	Female	Total	Progress
Outreach & Public Awareness					
Community members reached by BCC activities(70% of 1,300,000 targeted population)	154,117	54,015	96,363	150,378	98%
School children involved in BCC activities (30% 0f 1,300,000 targeted population)	29,102	16,103	19,605	35,708	123%
People in uniforms involved in BCC activities (about 100 by month / HZ)	1,173	303	76	379	32%

- **Number of service providers trained who serve vulnerable persons:** Performance on provider training generally lagged behind targets. As previously mentioned, this stems from the IPs' decision to prioritize service provision to survivors in the original seven zones during FY16. As mentioned, training of providers in new health zones continues and IMA believes this target will be met.
- **Community supervisors and mobilisers of VSLA**: At 147 percent, performance on this indicator surpassed the target. Training of community supervisors and mobilizers of VSLA was only to be done in the new health zones. Given the usual turnover of trained providers in the original health zones, IPs decided to train more providers than targeted in the new health zones.
- **Community mobilizers on GBV Prevention, Gender and Climate Change**: At 133 percent, performance on this indicator surpassed the target. Training of community mobilizers on GBV prevention, Gender and Climate Change was only to be done in the new health zones. Given the turnover of trained providers in the seven original health zones, IPs decided to train more providers than targeted in the new health zones.
- **Number of health centers supported:** The target number of health centers to be supported was estimated based on Ushindi being functional in 133 health areas. As explained above, Ushindi is currently operational in 108 health areas and supports one health center in each health area.
- **Youth clubs engaged in environmental and peacebuilding activities:** The target number of youth clubs to be created and supported was estimated based on Ushindi being functional in 133 health areas. Ushindi is currently operational in 108 health areas and supports one youth club in each health area.

III. Performance Plan and Report Indicators (Principal and Intermediate)

***IR1: Increased Access to Quality and Timely Care and Treatment Services**

During FY16, 3,064 survivors of sexual and gender based violence as well as a number of other vulnerable persons benefited from social services through the Ushindi project. Recognizing the multiple definitions of sexual and gender-based violence, the project considers a case of sexual violence as any incident of rape, sexual harassment or forced/early marriage. Other instances of gender based violence include all incidents of psychological/emotional violence, physical harassment and denial of resources or opportunities. The last category of service beneficiaries, vulnerable persons, includes all cases of fistula and vaginal prolapse.

Despite reaching the FY16 target, the number of beneficiaries supported this year is less than the average annual number of people reached during the first five years of the project. This gap can be explained by multiple factors:

- In the last three years of the project there has been an anticipated reduction in the overall number of survivors supported. At project inception, the target number of people who would benefit from Ushindi services over the project's first five years was 27,000. It was expected that following a decade of conflict, the first three years of the project would see the highest number of survivors being served; both acute and those in need of services for prior or long-standing abuse. These projections proved accurate during the fourth and fifth years of implementation, as the project saw a reduction in the overall number of survivors it served. Targets were consequently revised to reflect this change.
- Between October 2015 and January 2016, uncertainty about the future of the project led IPs to begin scaling down services across all sectors.

Of the 3,064 survivors who sought services through the project, 1,590 (52%) reported incidents of sexual violence, 1,406 (46%) reported other types of gender based violence, and 68 (2%) were considered "other vulnerable persons" (Table 5).

Table 5. Distribution of 3,064 SGBV survivors by Type of Violence (Oct 2015-Sep 2016)

Type of Violence	Male	Female	Total	%
All Types	321	2743	3064	-
Sexual Violence	23	1567	1590	52%
Other Gender Based Violence	298	1108	1406	46%
Other Vulnerable Persons	0	68	68	2%

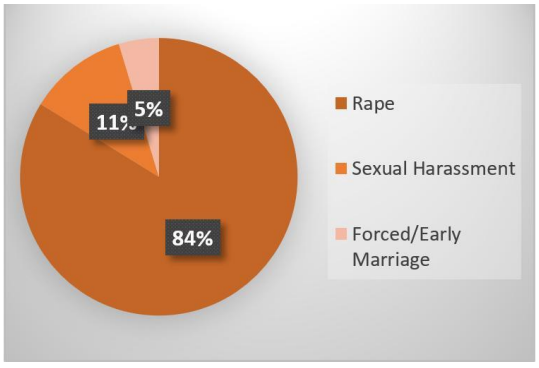


Figure 1. Sexual violence incidents by type of violence

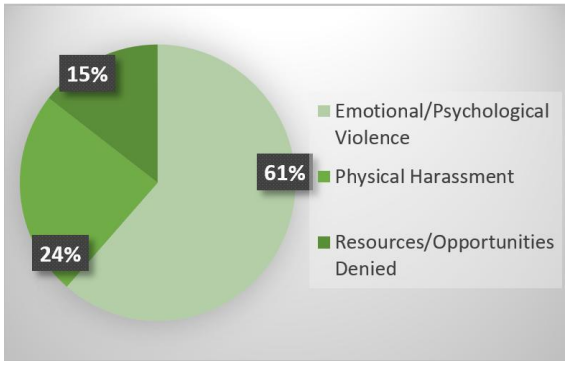


Figure 2. Other gender based violence incidents by type of violence

Most survivors who sought support through one of Ushindi's programs were female (2,743; 90%), at or over the age of 18 (1,975; 64%), and single (1,581; 52%). Table 6 shows the breakdown of survivors by gender, age and marital status.

Table 6. Characteristics of 3,064 SGBV survivors seeking services (Oct 2015-Sep 2016)

Characteristic	n	%
Gender		
Female	2,743	90%
Male	321	10%
Age		
≥ 18 years	1,975	64%
Under 18 years	1,089	36%
Marital Status		
Single	1,581	52%
Married	903	29%
Divorced/Separated	89	3%
Widow(er)	128	4%
Other	363	12%

- **Number of survivors counseled for psychosocial support**

During FY16, 2,945 survivors sought psychosocial support from the Ushindi project. Survivors of SGBV receive counseling initially through village based counselors who utilize basic techniques of active listening and relaxation exercises. Survivors who manifest symptoms of severe psychological distress are referred to senior counselors (psychologists). In August 2016, Ushindi introduced Cognitive Processing Therapy (see Section I), a higher level of psychological counseling, in its three new HZs.

Table 7. Distribution of people benefiting from psychosocial support by type of therapy received

Type of Therapy	Male (n/N)[1]	Female (n/N)	Total (n/N)	%
Any Type of Psychosocial Therapy	297	2649	2945	-
Active Listening and Counseling	297/297	2,649/2,649	2,945/2,945	100%
Relaxation Exercises	108/297	957/2,649	1,065/2,945	36%
CPT[2]	3/10	21/174	24/184	13%

[1]n/N – number of people who received this therapy/number of people evaluated for the therapy option. [2]Currently, CPT is only offered in the three new health zones. Over the one month that these health zones have begun offering services to SGBV survivors, 184 survivors have sought psychosocial services.

- **Number of survivors receiving medical support (including PEP, STI, and fistula care)**

Ushindi currently provides support to 108 health facilities across ten health zones. Survivors of sexual violence receive consultation free of charge (covered by project) as well as treatment with PEP kits for those survivors arriving within the critical 72-hour window period post-aggression. During FY16, 1,463 survivors of sexual violence sought medical care. Most of the cases received for medical care (1342, 92%) were rape survivors (Table 8).

Table 8. Distribution of 1,463 sexual violence survivors receiving medical care by primary reason for seeking care, Oct 2015-Sep 2016

Chief Complaint	N	%
All Complaints	1,463	-
Rape	1,342	92%
Physical Trauma	56	4%
Vaginal Prolapse	47	3%
Fistula	18	1%

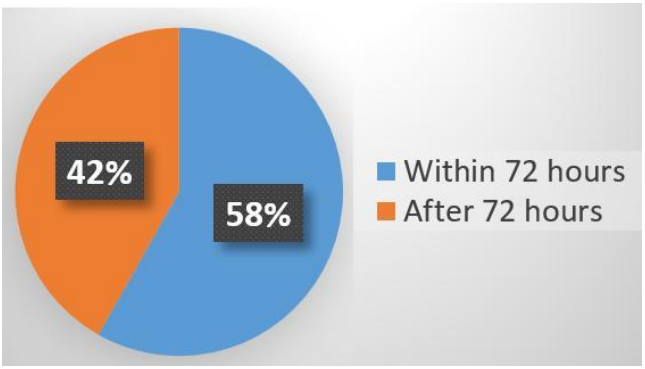


Figure 3. Distribution of 1,342 rape survivors receiving medical care by time after incident, FY16

Of the 1,342 rape cases received at health centers, only 781 (58.2%) arrived within 72 hours of the incident (Figure 3). In addition to receiving cases of sexual violence originating from their respective health zones, Ushindi service providers have reported an increase in the number of survivors from health zones and areas not served by Ushindi. SGBV survivors from neighboring health zones which lack appropriate health services are increasingly seeking support within Ushindi. Given longer travel distances and lack of adequate transportation, these survivors typically arrive beyond the 72-hour window after the incident. The Ushindi project has not been tracking separately the number of survivors coming from non-Ushindi health zones and is now examining how to monitor these numbers better. Additionally, the current conflict situation in Ituri and Northern North Kivu has caused internal displacement of population in areas where Ushindi serves; displacement increases the time and distance survivors must confront to seek care. Despite these challenges, IMA approached its target of 60 percent this reporting period.

All of those who arrived within 72 hours of an incident received PEP kits containing STI prophylaxis. Of the 561 survivors who came beyond the 72-hour window, 496 (88.4%) received STI treatment.

• Number of survivors receiving legal support (for GBV and SV)

ABA ROLI staff at its legal clinics are responsible for filing cases with the local police stations and monitoring their progress as they advance through the judicial system. During FY16, ABA ROLI provided legal counseling at nine legal aid clinics in the Ushindi project (staffed by lawyers and paralegals) to a total of 1,216 people, including 590 survivors of sexual violence and 626 survivors of other incidents of gender based violence (Table 9). Since the project start-up in 2010, the number of survivors seeking legal assistance has continued to increase.

Table 9. Summary of legal services provided through the Ushindi project, Oct 2015-Sep 2016

Indicator Title	FY 16 Targets	FY 16 Achievements			
Program Element Indicators	**Target**	**Male**	**Female**	**Total**	**Progress**
People requesting legal support	880	138	1,078	1,216	138%
**People receiving legal support - Sexual Violence Incident*	493	5	585	590	120%
**People receiving legal support - other GBV Incident*	387	133	493	626	162%
Cases taken to court	246	4	324	328	133%
**Number of judgments*	62	0	16	16	26%
**Number of mediations achieved*	271	56	236	292	108%

***IR2: Increased organizational and community capacity to respond to SGBV (BCC) and reintegration of survivors**

• Number of survivors enrolled in VSLA groups

Survivors of SGBV are referred to the VSLAs, and implementing partners report increasing uptake of services. However, due to issues of confidentiality and stigmatization, many of those who join prefer not to disclose their SGBV experiences upon enrollment. Survivor identification is done throughout the year by trusted psychosocial counselors. As of March 2016, these counselors had identified 421 survivors among those enrolled. As of September 2016, an additional 43 survivors have been identified. However, identification is not yet complete and we estimate that the number of survivors who enrolled during the second semester of FY16 exceeds 43.

***IR3: Improved ability of communities and individuals to lead and participate in community-based social integration and economic recovery activities**

• Number of people assisted by social fund

Ushindi initiated VSLA groups early in the project through the technical assistance of CARE International, which provided tools, training, seed funds, and oversight. VSLAs focus on funding income-generating activities which support day-to-day social needs such as nutrition, schooling, and health needs. Each member of the VLSA makes a small contribution at each meeting to a social fund. This fund helps meet community needs such as funerals, birth of children, illness, housing repair, etc. This reporting period, all IPs reported consistent use of social funds by VSLA communities.

Since the project's debut, 1,105 VSLAs have been created, of which 192 were created during this reporting period. Today, these 1,105 groups constitute 34,877 members. Due to the large number of organizations being created and the limited number of VSLA community supervisors (4 per health area), the project has been keeping track of data from a fixed number of VSLAs (272) for reporting purposes. During FY16, monthly reports came in regularly from 272 VSLAs. These VSLAs generated a total of $477,409 in savings and disbursed $384,108 in loans (Table 10).

Table 10. Financial Summary for 272 VSLAs monitored regularly, Oct 2015-Sep 2016

TOTAL VALUE of VLSA Shares (of 272 VSLAs reporting products this cycle)Oct 15 to Sept 16				
	Heal	PPSSP	Panzi	Totals
Number of shares purchased by members	457,116	257,690	113,740	828,546
Net Value of shares (in USD)	$188,301.61	$160,310	$128,798	$477,409
Value of shares in other forms (goods convertible to USD)	$0	$7,142	$1,311	$8,453
Number of credits granted (from VSLA funds)	4,345	2,181	1,240	7,766
Value of credits granted from VSLA funds	$175,488.53	$96,143	$112,476	$384,108
Balance unpaid from loans by members	$0	$4,847	$658	$5,505
Amount in USD from solidarity Basket funds to VSLA groups	$12,019.15	$13,759	$9,930	$35,708
Number of members assisted by social fund	2,589	2,039	858	5,486

***IR 4: Number of organizations' delivery systems strengthened**

An important objective of the Ushindi project is to strengthen the systems that support survivors of sexual and gender based violence. The project seeks to reinforce the capacity of health centers, safe houses, legal clinics and other social service structures to remain functional and provide services to SGBV survivors.

• Number of health facilities supplied with appropriate medicine and supplies

By the end of FY16, the Ushindi project was operational in 108 health areas across 10 health zones. All survivors who sought medical care at one of these facilities received consultation free of charge (covered by project). Those who presented within 72 hours of the reported incident were given PEP kits, while those presenting after 72 hours were offered STI prophylaxis or treatment and emergency contraception in

accordance with national guidelines. During this reporting period 1,200 PEP kits were distributed to all 108 health clinics in collaboration with the BCZS.

• CBOs, NGOs, and other groups and associations created with Ushindi's support

During FY16, the project has notably made the following contributions in this area:

- 36 new youth clubs were established (12 per health zone in the three new health zones) and received training to help provide safe environments for children and to involve them in community outreach activities for SGBV and gender rights, especially amongst their peers. In the original seven health zones, 72 existing youth clubs received similar support from Ushindi.
- In addition to the 72 community core groups (*noyaux*) active in the original seven health zones, an additional 36 were created in the three new health zones this reporting period.
- 192 new VSLAs were created during this reporting period across all HZs.

• Youth clubs

Ushindi supports local community groups that learn from and engage in activities related to the prevention of SGBV. Youth clubs remain active in most health zones; the more sustainable ones are those that are self-supported. Youth clubs hold sessions/discussions on the impact of SGBV on family, school, church, and community. Other sessions have dealt with social issues such as the dangers of early marriage, consequences of drugs, and importance of caring for our bodies. This semester, youth clubs started environmental activities such as nurseries and reforestation (see Section IV-J).

IV. Highlights from current Reporting Period

A. Ushindi Expands into Three New Zones!

In August 2016, in accordance with our revised Cooperative Agreement with USAID (18-month extension), Ushindi extended into three new health zones with the intent of modeling best practices in accordance with evidence-based data and lessons learned from an impact evaluation carried out in July 2016. These new zones would also be sites to launch CPT-level counseling services for survivors of SGBV.

1. Selection Process/DPS

According to the SOW in the Cooperative Agreement, *"Ushindi was to test a first phase extension of the project into USAID priority areas in the Kivus, which will at the same time contribute to further refinement of the model. It is anticipated that the project will begin to implement in 2-3 new health zones."*

The selection of these health zones was carried out in consultation with USAID and DPS and based on both geographic criteria (TOT 1-2) and unmet needs in SGBV. IMA is an active member of the Gender Multi Sectorial working group (GBV-AMS) headed by UNICEF and the Ministry of Health. Monthly meetings are organized to share achievements, mitigate gaps in terms of SGBV prevention, and assure provision of adequate care and support to survivors in the provinces of North Kivu, South Kivu, and Ituri.

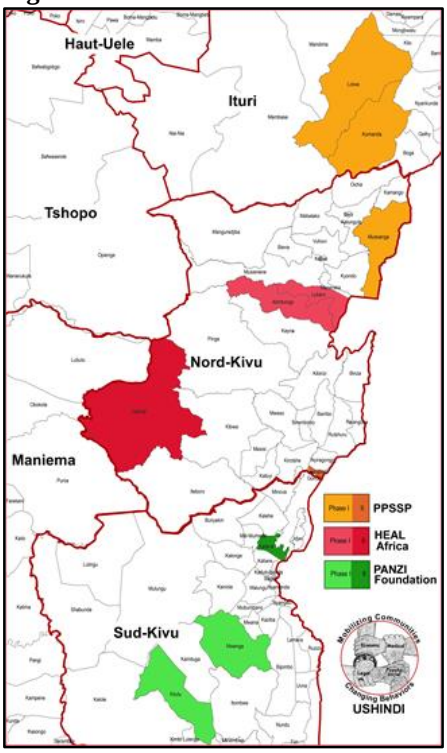
Selections were based upon the following rationales:

> Walikale: (USAID TOT-2) Increasing SGBV needs in light of continued insecurity, heightened by the departure of IMC (International Medical Corps) with no new organization to fill that gap. GBV-AMS priority area.

Karisimbi (USAID TOT-1) High incidence of SGBV (especially among youth), exacerbated by increased usage of alcohol. GBV-AMS priority area.

Katana: (USAID TOT-1) GBV-AMS priority area and absence of SGBV partner. In 2014 the Katana Health Zone was divided into Kalehe, Miti-Murhesa, and Katana HZs. Panzi Foundation already supported Kalehe and Miti-Murhesa with private funding leaving a large gap in the Katana HZ, less than 8 km from the airport of Kavumu.

Figure 4. Ushindi-Assisted Health Zones



2. Verified Need

A Population-Based Household Study to Assess Practical Strategies of Prevention and Response to Sexual and Gender Based Violence in Katana, Walikale, and Karisimbi Health Zones, conducted in July 2016 by the external consultant OSC, highlighted the high prevalence of SGBV (32% women, 33% men, 61% children) among the surveyed population, confirming the significant need expressed by GBV-AMS. Exacerbating the situation in these zones, particularly Walikale, were the perpetuation of harmful traditional practices, accepted social norms, evidence of human trafficking, and high numbers of mental illness including depression and PTSD.

3. Kick Off!

*Intensive training of health care providers, psychosocial counselors, legal jurists, *noyaux*, youth clubs, school directors, community leaders, etc. was carried out throughout the month of August in all three new health zones. A table of the total number of persons trained is in Section M, page 33.

*Procurement and distribution of over $300,000 worth of inventory was undertaken in the three new zones from July-September. A short summary of materials procured is below:

Table 11. Inventory received in the three new health zones

Quantity	Item	Description
1	Vehicle	Toyota Land Cruiser
6	Motorcycles	Yamaha DT 125
20	Laptops	Lenovo i5 500GB 8Ram
3	Solar lighting kits	Panels/invertor/batteries/lights
900	PEP kits	HIV/STI prevention
200	SBCC material	Brochures/stickers/banners
120	Tee shirts/caps	Shirts/caps for launch
40	Protective jackets	Branded USAID/Ushindi for staff
1,524	Posters	Ushindi services
1,446	Posters	Clinical management of SGBB
4	Printers	For IP offices
2,761	Training modules	For training in three new HZs

*Opening ceremonies were carried out in all three health zones in August-September 2016, with involvement of government officials and community leaders.

Delivering Supplies to Safe House in Karisimbi (Aug 16)

Motorcycles for IP-supervision of new zones (Jul 16)

New vehicle and motos delivered to Panzi Foundation (Aug 16)

…..to support Katana Health Zone in Katana (Sep 16)

Handover of keys to Panzi (Aug 16)

Reception by Dr. Denis Mukwege (Aug 16)

Launch of Ushindi in Walikale (Aug 16)

Official opening of Ushindi in Karisimbi (Aug 16)

Psychosocial counselors for Karisimbi receiving training certificates (Aug 16)

Kick-off celebration of Ushindi in Katana Health Zone (above and below) (Aug 16)

Official reception with Territory Commissioner (Walikale Aug 16)

Youth in Walikale participating in launch of Ushindi (Aug16)

Delivery of materials to Safe House Karisimbi (Aug 16)

B. Capacity Building of Ushindi Implementing Partners

IMA leads a consortium of all-national implementing partners (PPSSP, Panzi, HEAL Africa), all with an extensive history of providing services to victims of SGBV in contextually challenging settings. National NGOs such as HEAL and Panzi have the advantage of resiliency (in times of conflict), flexibility (in changing contexts) and identification (origin) with community stakeholders. IMA recognizes its responsibility to further these advantages by strengthening the capacity of our national partners, providing technical support in areas such as grants management, financial accountability, data analysis/research methodology, and strategic planning.

The IMA Ushindi team (SGBV Expert, M&E Expert, Finance and Grants Management team, and consultants in areas such as CPT, Positive Masculinity, Environmental Care, Research, and others) has invested significant time and resources both to increase the capacity of our partners in managing grants and contracts and also to provide the essential tools and training to enhance their technical reach and effectiveness.

This past semester IMA facilitated workshops in CPT, financial reporting, fraud awareness, operational research, health zone mapping, and others to build the capacity of our partners. IMA undertakes supportive supervision visits each month to partner-supported zones. Table 12 shows a list of capacity-building conferences held in the past six months (Apr-Sep 2016) for IP and project staff.

Table 12. Capacity-building support sessions for Ushindi IPs

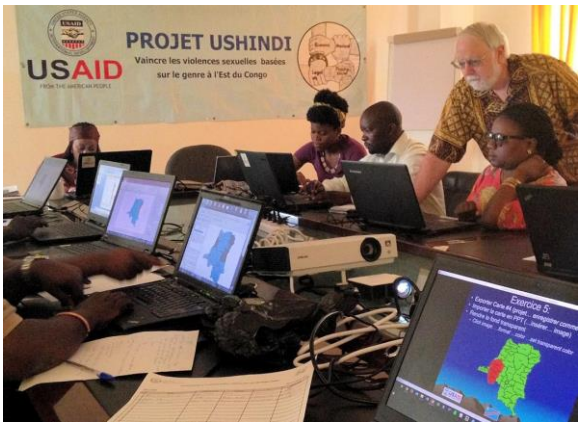
Month	Staff	Origin	Subject
Apr-16	Louise Bashege	IMA Goma	Psycho-Social Reporting Tools
	Dr Frank Baer	IMA Sr Consultant	Grants Mgt/Leadership
	Riddy and Co	Kinshasa	Data Colletion /Java Data Base
	IMA Ushindi Staff	IMA Goma	Supportive Supervision
May-16	Dr Lynn Lawry	OSC	Research Impact
	IMA Ushindi Staff	IMA Goma	Supportive Supervision
Jun-16	Manka Banda	Emory Univ	Data Analysis (Ushindi DataBank)
	IMA Ushindi Staff	IMA Goma	Supportive Supervision
16-Jul	Jura Augustin	Johns Hopkins	ME Tools for CPT Therapy
	Lior Miller	IMA DC Staff	Psychologists in SGBV Care
	Deb Kaysen	Univ Washington	Formal CPT Training
	Paul Bolton	Johns Hopkins Un	Formal CPT Training
	Wayne Niles	IMA Kinshasa Staff	Technical Use of Server
	IMA Ushindi Staff	IMA Goma	Supportive Supervision
Aug-16	Pako Samuna	IMA Kinshasa Staff	Principles of USAID
	Ron Ottson	IMA DC Staff	Anti-Fraud
	Carine Mukengashi	IMA Kinshasa Staff	Human Resource
Sep-16	IMA Ushindi Staff	IMA Goma	Health Services
	IMA Ushindi Staff	IMA Goma	Psycho Soc Services
	IMA Ushindi Staff	IMA Goma	Socio-Econ Services
	IMA Ushindi Staff	IMA Goma	SBCC/Outreach

Participants with their certificates following CPT training (Jun 16)

Training in financial management by Pako Samuna (Aug 16)

Training in fraud prevention by Ron Otteson (Aug 16)

Dr. Debra Kaysen (UWash) teaching key concepts in CPT (Jul 16)



Dr. Franklin Baer teaching QGIS mapping (Oct 16)

C. Impact Evaluation

Overview:

In accordance with IMA's 18-month extension and modified Cooperative Agreement, an impact evaluation was requested to gauge the impact of the five-year Ushindi project and whether Ushindi had achieved its planned results at the conclusion of its five-year implementation. IMA included the impact evaluation in the extended SOW of Overseas Strategic Consulting, Ltd., for reasons of adaptation and conformity (same tools/methodology could then be used to do a baseline survey in the three new zones), familiarity with the Ushindi program, and cost-savings from start-up and field time. The impact evaluation of the project would include analysis of the project's quantitative data collected by IMA and its partners over the five-year course of the project, comprising 79,000 data sheets. The primary objective of this evaluation was to determine the overall impact the Ushindi program has had on survivors of sexual and gender based violence and what impact it has had on local communities in terms of awareness and prevention of SGBV and promotion of gender rights.

Methodology:

The study was limited by the lack of a true baseline before project implementation in 2010 (the baseline and impact survey was done in late 2011) and thus a non-experimental approach as outlined above was utilized to assess impact. The methodology involved a mixed quasi-experimental approach which included four components:

- An extensive desk review
- Semi-directed (qualitative) interviews with survivors and key community stakeholders
- Quantitative analysis of programmatic data collected over five years (79,000 data sheets)
- Lot Quality Assurance Sampling (LQAS) of opinions and attitudes

Summary Findings (from Executive Summary, OSC report)

Ushindi has been successful and cost-effective for ensuring medical, psychosocial, socioeconomic and justice is available should survivors want and need such services. The documented impacts of Ushindi include increasing community knowledge about SGBV; increasing the number of survivors who present to care within the 72-hour window to receive PEP; a constant, cost-effective and reliable supply of PEP kits to the health centers in Ushindi implementation areas; improvement in the knowledge of health care personnel at the health center level to identify and treat survivors of sexual violence; a context-specific and accepted method for psychosocial care; the implementation of higher level, evidence-based treatment for PTSD and severe depression (CPT); and significant and important effort to bring cases of sexual violence to court and push for a judgment.

Specific findings favorable to the project (from the OSC report) were:

- Ushindi had a significant impact on survivors' ability to seek care and access services that were not previously available to address the known sequel of sexual violence.
- More than three-quarters of the survivors interviewed were aware of Ushindi and its support services such as the *noyaux*, counselors, legal assistance and the safe houses
- Community awareness of support structures of survivors were well known largely due to the activities of the *noyaux* communautaire who pointed survivors in the direction of to all arms of the services
- Anecdotally, among survivors interviewed, Ushindi's programs (specifically the medical services, safe houses and psychological care) were the most commonly mentioned services that helped them "recover"
- Survivors rely heavily on the lay counselors associated with the safe houses and communities and credit them with their comfort and recovery.
- Safe houses are important for combined service access and represent a safe/calm/welcoming place for survivors
- PEP kits used during the five years of Ushindi increased also suggesting that survivors were coming to care earlier (within 72 hours)
- PEP kits are used appropriately by providers who feel more confident about the use of National Treatment Guidelines for the identification and treatment of survivors since the start of Ushindi
- Ushindi was able to consistently supply PEP kits to health centers and even with a limited stock out period, providers and clinics had enough kits to share until replacements were supplied. The outside sourcing model for PEP kits by IMA was cost-effective and efficient and should be replicated by others to ensure important treatments are available.
- More than half (56%) of cases brought to the legal clinics were pursued.
- Given the difficulties of the judicial system in DRC, the fact that 21 percent of cases reach a judgment heralds a significant effort by the ABA to pursue justice for victims.
- Anecdotally, the fact that sexual violence is prosecuted and sentences have been given fear about being held accountable is instilled in communities
- Anecdotally, the establishment of 108 youth clubs (30,000 participants), 108 *noyaux*, 415 VSLAs, nine child protection networks (RECOPE), over 100,000 mass community awareness-raising sessions in villages, and 26 women-led IGA/CBOs all added to community knowledge and awareness of sexual violence and information for the community to help survivors reach out to seek necessary care

Improvements needed (per the OSC report)

Improvements to the program are minor and include things such as increasing the capacity of local partners to adapt their traditional communication programs to SBCC that focuses on behavior change, packaging PEP kits to decrease the temptation to use parts of the kits for other diagnoses, considering other socioeconomic approaches for education and/or documenting the increase in financial independence. In the next phase of Ushindi, the intake data forms should have indicators added that might help with demonstrating impact, such as adding in periodic symptom monitoring of mental health disorders associated with SGBV and better data to evaluate if survivors are indeed coming to care within 72 hours.

Specific areas that need revision/improvement are:

- The impact and financial improvement from participation in VSLA among households of survivors could not be determined.
- Anecdotally, the survivors report economic hardship due to the inability to complete activities of daily living due to psychological distress or simply fear of walking to the fields or by the bush.
- Survivors interviewed were not as aware of legal services compared with other components of Ushindi. Few of the survivors interviewed had pursued cases, largely due to held beliefs that justice was not possible.
- Local Chiefs are still mediating certain cases as a first intervention, especially those involving minors and/or IPV cases, which when that fails they then go to legal clinics.
- Families are making the decisions for young girls ((14-21) and using community mediation to protect the family name and to obtain the financial incentive imposed by the Chief on the perpetrator. The compensation is paid to the family and not the survivor.
- Determination of impact and literacy from the participation of literacy clubs could not be determined or measured, and few if any survivors could verbalize any type of true impact on their recovery or lives.
- Foster families had little or no measurable impact on child SGBV survivors and could only house a minimum of survivors (at a significant cost to the program).
- The sustainability of payments to the health zone and health clinics for the care of survivors is questionable if Ushindi does not exist.

Follow up:

Both the baseline survey and impact evaluation offer Ushindi, its partners, and USAID valuable information to gauge the overall prevalence of SGBV in Eastern DRC, examine demographics including gender and age, and evaluate the significant negative impact SGBV is having on physical and mental health, socio-economic development, and the prospects of peace and stability in communities and districts in this area.

IMA has integrated lessons learned in the first phase of Ushindi into the new extension phase. With the awareness that up to 30 percent of those receiving psychosocial services do not regain their previous functionality, IMA has introduced and is implementing CPT therapy in 36 health areas with trained CPT counselors for early screening and referral of eligible survivors to the psychologists. The database of collection tools has been refined to collect indicators such as trafficking, use of socio-economic services, and timing of incident vs services. IMA has introduced new SBCC tools to encourage uptake of legal services and has provided training on the limits of mediation and need for legal (vs traditional) judgments. Youth club activities are being enhanced with new skills, including the introduction of concepts of "positive masculinity" in SBCC and formation of environmental clubs which will increase participation and generate additional opportunities to foster dialogue on prevention of sexual violence among adolescents and promoting gender equity and empowerment.

Activities with little evidence of relative impact (such as literacy and foster families) are being downsized, while services at safe houses and mobile counseling are being enhanced. VSLA-centered strategies to

increase participation of survivors in existing groups and tools to record their participation are being strengthened. Individual PEP kits are being packaged by IMA with support from the Pharmaceutical Direction, and the Health Zone office (BCZS) is involved in both distribution of kits as well as case management of services and training of new workers.

Lastly, IMA is in discussion with both OSC and University of Washington regarding an end-of-year survey or assessment to gauge progress as well as enhance tools and methods to better monitor and create modalities for ongoing assessment and evaluation of this extension-phase of Ushindi, designed as a refined, comprehensive, evidence based, and stronger package of intervention for survivors of SGBV!

D. Baseline Survey

As part of the 18-month costed extension, IMA was asked to undertake a baseline survey of SGBV in Eastern DRC, focusing on health zones where IMA would be expanding; the survey would serve both to provide a baseline of the prevalence of SGBV in areas where Ushindi would start up in August 2016 as well as provide (by statistical analysis) an estimation of the prevalence of SGBV in the larger area of North and South Kivu Provinces. IMA engaged the services of Overseas Strategic Consulting, Ltd. (OSC), with Senior Director of Research and Evaluation, Dr. Lynn Lawry, undertaking the study. An internationally recognized researcher, Dr. Lawry contributed to a benchmark SGBV prevalence study in Eastern Congo in 2010, published by the *Journal of the American Medical Association*, [1] and brought the distinct advantages of extensive local experience plus proficiency in comparative collection tools and methodology required to gauge changes from 2010 and provide an accurate baseline survey that would include comparison to past data and trends.

The randomized population-based study of 900 households was undertaken in July 2016 in the three health zones of Karisimbi (NK), Walikale (NK), and Katana (SK). The overall objective of the survey was to determine the documented prevalence of all forms of gender based violence, with particular focus on trafficking, mental health, and demographic breakdown. The study was to look at what services are available for survivors of SGBV and identify gaps/obstacles in service provision. The study was reviewed and approved by the *Comité D'Ethique, Université Libre Des Pays Des Grand Lacs* (ULPGL), Goma. A summary of the findings is below:

- **SGBV and Sexual Violence**

  The study revealed (see Table at right) surprisingly high prevalence of all forms of SGBV, with near equal involvement of both genders and a disturbingly high number of children. Sexual violence (as a component of SGBV) had an overall lifetime prevalence of 11-12 percent in women and children.

  The prevalence of all forms of SGBV including intimate partner violence (IPV) and trafficking were prevalent not just among women but also among men and children.

- **Trafficking**

  Twelve percent of households self-reported trafficking. Based on population estimates in the three surveyed health zones, 30,719 adults are affected by trafficking, including 18,286 women and 12,432 men. Five percent of households reported trafficking of household children. The most common forms of trafficking among adults included: forced to work in a

Table 13. **SGBV Prevalence (Lifetime)**

SGBV	
• **Women**	• 31.6%
• **Men**	• 32.9%
• **Childre n**	• 61.0%
Sexual Violence	
• **Women**	• 11.8%
• **Men**	• 3.1%
• **Childre n**	• 11%

[1] Johnson K, Scott J, Rughita B, Asher J, Kisielewski M. Ong R, Lawry L. Association of Sexual Violence and Human Rights Violations with Physical and Mental Health in Territories of the Democratic Republic of Congo. JAMA. 2010.

bar/bistro, forced to be domestic help and forced indebtedness (in Karisimbi), forced indebtedness, held against will and forced to carry goods from a mine (in Katana and in Walikale). Dividing the abuses into the categories of debt bondage, labor trafficking and sex trafficking, and taking into account that respondents could list more than one type of trafficking, one-third of respondents listed a form of trafficking in each of the categories.

- **Depression/Anxiety/PTSD/Suicide**

  Symptoms of depression/anxiety and PTSD were equally prevalent among both men and women and were elevated in association with SGBV, sexual violence, and IPV. The population rate of symptoms consistent with depression/anxiety was 27 percent. Overall, women trended towards higher symptom rates of depression/anxiety than men but there was no statistical difference in these numbers. The population rate of symptoms consistent with PTSD was 23 percent. Twenty-seven percent of respondents reported suicidal ideation and 15 percent reported a previous suicide attempt in their lifetime.

Teaching principles of random selection **(**July 16**)**

Modeling interview skills (Walikale, July 16)

Role-playing with Dr. Lawry, left (Katana, July 16)

Surveying in Karisimbi…plotting household visits (Jul 16)

E. CPT Roll Out

1. Background

Preliminary findings from the OSC-led impact evaluation and an examination of the Ushindi database (2010-2015) suggest that up to 25 percent of survivors of SGBV who receive lay counseling could benefit from further, more advanced counseling. This is consistent with the *New England Journal of Medicine* article by Dr. Judith Bass [2]which showed a significant improvement in both depression and PTSD in survivors of sexual violence who received a higher level of counseling known as Cognitive Processing Therapy (CPT) compared to those who received conventional therapy. Accordingly, IMA and USAID agreed for Ushindi to initiate CPT in two to three new health zones during a costed extension period. During this reporting period, Ushindi successfully initiated CPT services in the three new health zones of Walikale, Katana, and Karisimbi.

2. Training and Preparation (June-July 2016)

Two training workshops were organized in Goma in June and July 2016:

- The first session (June 2016) on the use of revised monitoring and evaluation and collection tools was led by staff from Johns Hopkins University and included eight psychologists from Ushindi IPs as well as representatives from the MOH Direction of Mental Health and ULPGL Faculty. CPT indicators, collection methodology and reporting tools were defined.
- The second session (July 2016) on providing CPT was led by faculty from the University of Washington and trained 13 project and partner psychologists, including staff from the MOH and ULPGL. Following this training, Ushindi psychologists traveled to the three supported health zones to train lay counselors on diagnosis and referral indications for CPT.

3. Implementation Phase (August 2016-present)

- Clinical activities started in August and September as specific health areas were enrolled in the Ushindi program in the three target zones. By the end of September, a total of 24 survivors had been identified and enrolled in individual or group CPT counseling.
- Therapists in the field are monitored on a weekly basis by CPT supervisors from all three partners. Reports are shared and centralized by the IMA/SGBV/TA to ensure selection of cases and therapy is proceeding according to protocol Weekly sessions (by Skype) are held with faculty at the University of Washington to discuss individual cases (coded by number), specific challenges, solutions, and pathways forward. Intense weekly contact and feedback is assured between counselors in the field and staff in Seattle during the first six to twelve months of implementation.

Jura Augustin (JHU) teaches M&E CPT Collection tools (Jun 16)

Ushindi staff psychologists in CPT training (Jul 16)

[2] Judith K Bass, et al. Controlled Trial of Psychotherapy for Congolese Survivors of Sexual Violence, New England Journal of Medicine (2013)

Dr. Ivan Bolton (UW) doing practical workshops with Ushindi psychologists and staff (Jul 16)

Ushindi senior psychologists reviewing referral guidelines for CPT with lay community psychosocial counselors in Walikale (Aug 16)

F. Communication for Change (SBCC)

Communication for Change is an activity which is integrated into all aspects of the Ushindi project and is intended to increase utilization of services, enhance awareness of SGBV, and lay the foundations for durable change.

Key strategies for SBCC in Ushindi include advocacy and awareness activities by the *noyaux communautaires* in all health areas with strong support from local leaders (political, traditional, educational, religious, etc.). In addition, specific activities such as youth clubs, campaigns, radio

messages, and forums are used throughout the program to disseminate messages and themes. To further support SBCC, printed material such as pamphlets, posters, brochures, and banners are distributed in all health areas supported by the project and displayed in the most suitable (and busiest) public places to optimize exposure among target groups, places such as health centers, community cores groups, schools, churches, and health zone offices.

This past reporting period, Ushindi developed and disseminated two new posters and six wall stickers and distributed them widely. Six types of posters and stickers were produced in a local language (Kiswahili) with key messages on the following::

- Importance of medical treatment within 72 hours
- Definition of SGBV
- Risks of pregnancies of minors
- Registration benefits of marriage to the civil state
- Involvement of all in the performance of domestic tasks
- Importance of good management of hospital waste

Left: New display stickers (6); Right: two posters distributed throughout Ushindi-supported health zones this period.

Distribution of posters to community leaders (Walikale, Aug 16)

G. PEP Kits… Leading the Way in Reliability and Innovation

Providing PEP kits to survivors of sexual violence is an essential element of the medical component of SGBV and saves lives! Despite issues of access (security) and global stock-outs by UNICEF and WHO, the Ushindi project has had a distinguished record of supply chain to over 108 health facilities. During this reporting period as well, no stock-outs or expiration of PEP kits were reported.

One of the recommendations from the OSC evaluation was to better secure and package the PEP kits so they would be preserved and utilized exclusively for cases of SGBV. In collaboration with the Ministry of Health Division of Pharmaceuticals, Ushindi designed and packaged their own PEP kits this reporting period. Printed labels signed by the DPS, with dosing requirements and expiration dates stated, were included in kits pre-packed on-site in Goma. Typically, 'kitting' of PEP kits internationally can add months to delivery time, tie up procurement, and add unwarranted costs. During a two-day period, IMA, along with a team from the DPS, packaged and labeled over 900 PEP kits for distribution to our health facilities. "*Conservation-Collaboration-Cost Saving-and-Cutting Edge*"… to assure quality and timely medical products to over 130 Ushindi service facilities!

Ushindi SGBV Advisor, Dr. Alice Mudekereza (top right), with members from DPS and IMA volunteers, assembling PEP kits under the direction of Provincial Pharmacy Inspector M. Henri Takenga (middle left)

H. VSLA and Socio-Economic Reintegration

To address and prevent gender based violence, the Ushindi project supports community reintegration activities for survivors of violence and other vulnerable persons in ten health zones. The following are highlights of the Socio-Economic Program:

1. VSLA activities during this reporting period

- Of a total of 876 VSLAs planned to date, 1,105 have been started (126% of target). Women account for roughly 77 percent of members.
- The proportion of SGBV survivors in VSLAs is currently 45 percent of target (3,762 of an expected 8,389).

Table 14. VSLA activity for this reporting period (Oct. 2015-Sep 2016)

Indicators	Targets/Annual	Realised	%Progress
No of current VSLAs	432	913	211%
No of new VSLAs this reporting cycle	444	192	43%
Total no of VSLAs to Date	876	1,105	126%
No of current members in VSLAs	12,526	27,752	222%
No of new members this reporting cycle	13,300	6,848	51%
Total no of members to date	19,176	34,600	180%
No of SGVB survivors currently enrolled	8,169	3,341	41%
No of new SGVB surviors enrolled this cycle	440	421	96%
Total number of Survivors in VLSA to date	8,389	3,762	45%
No of people enrolled in regulary reporting VSLAs this cycle sept 16	19,176	7125	37%
No of people enrolled in regulary reporting VSLAs and completing this cycle sept 16	19,176	7125	37%
No of VSLAs reporting regularly their products this cycle oct 15 to sept 16	876	272	31%

2. Total value of shares tabulated during this reporting period:

- A total of $ 477,409 was mobilized by members in all supported VLSAs.
- A total of $ 384,108 has been given out as loans to community members.
- A total of 5,486 members have been assisted by the social fund.

3. Impact of VSLA activities in the community

The impact and effects of this approach in the areas of intervention are seen through two phenomena:

Increased number of self-started VSLAs

- The enthusiasm of VSLAs is reflected in the fact that during this past reporting period 16 VLSAs on average were started each month, with an approximately 30 members each. We have reports of VLSAs continuously being started outside Ushindi health zones, proximal to current sites and modeled after the Ushindi program.
- The contribution of this program to the economic empowerment of women is irrefutable, with nearly 35,000 women enrolled and over $375,000 in loans disbursed in five years. The inclusion of survivors of SGBV is now better documented than previously, with a total of 464 this past reporting period.

Lock Boxes in Walikale for Distribution to new VLSAs (Aug 16)

VSLAs' innovative networking!

- A number of VSLAs seeking to strengthen their economic capital have begun to initiate platforms called "*Réseaux d'Associations Villageoises d'Epargnes et de Crédits"* (RAVEC).
- This network is an association of VSLAs which fosters both legitimacy as well as assistance between branches. There are currently nine RAVEC platforms that have been established; six are operational and three in the launch phase. The table below provides a summary of that activity.

Table 15. Total of Networks Initiated this Reporting Period

Total of Networks initiated this reporting period					
Zones de Sante	**Aire de Sante**	**Nbre RAVEC constitues**	**Nbre AVEC/Membres**	**Date de constitution**	**Observation**
Kitutu	Sugulu	1	48	May-16	Phase/operationnelle
Mwenga	Kilambwigali	1	19	May-16	Phase/operationnelle
Lubero	Mubana	1	9	Jul-16	Phase/operationnelle
	Lubero - centre	1	10	Jul-16	Phase/operationnelle
Alimbongo	Kaseghe	1	6	Jul-16	Phase/operationnelle
	Alimbongo - centre	1	12	Jul-16	Phase/operationnelle
Komanda - Lolwa	Idohu	1	8	Aug-16	Phase/lancement
	Mabukulu	1	5	Aug-16	Phase/lancement
	Manya	1	7	Sep-16	Phase/lancement
Total		**9**	**124**		

I. Positive Masculinity

This reporting period, IMA has introduced programming in positive masculinity (PM) in its community leadership and youth club activities. The focus of PM is to engage men and boys in SGBV prevention, challenging the negative aspects of cultural norms and fostering positive attitudes, behaviors, and practices.

IMA in collaboration with the Ministry of Gender has introduced a curriculum in positive masculinity in its training programs in the three new zones. A consultant from the MOH is working in the health zones of Walikale, Katana, and Karisimbi doing focused training of community groups (*noyaux* and youth clubs)

and leaders. The response in the first month of training has been very encouraging. As of this reporting date, with the first month of training underway, 900 persons have received training in this innovative strategy to change community norms and behavior from the 'individual- up'. Of a total of 900 people sensitized in the positive masculinity approach in the first month, men accounted for 58 percent and women 42 percent. Young people accounted for only six percent of the total; hence, there is a need to involve more young people in the coming months. IMA plans on intensifying introduction of positive masculinity sensitization in youth clubs in the coming months.

Table 16. Positive masculinity training

Zones Sante	#Women	#Men	#Total
Walikale	99	211	310
Karisimbi	161	139	300
Katana	172	118	290
Total	**432**	**468**	**900**

Training of youth group in positive masculinity in Walikale

Training sessions in positive masculinity in Walikale and Katana Health Zones

J. Environmental Youth Clubs

With the aim of supporting Ushindi's effort to mitigate the environmental impact of foreign assistance and development projects and to provide a positive focus in support of environmental efforts, the Ushindi project is integrating environmental protection activities in its SGVB programming during this extension period. The objectives of such activities are three-fold:

1. Provide appropriate management of solid and wet waste generated from project-related and other activities.

2. To provide the community (especially youth) with practical knowledge related to environmental protection in order to help foster positive behaviors, attitudes and practices to improve socio-environmental and health conditions at the community level.
3. To popularize the importance of the role of trees and reforestation, and in particular to address local issues of soil degradation and erosion and the global issue of climate change.

This past semester, Ushindi worked synergistically with World Wildlife Fund (WWF) to obtain curriculum and essential materials to introduce the concept of reforestation and other environmental activities within the *noyaux* and youth clubs in its expansion areas. During this reporting period, Ushindi worked with community organizations in Walikale, Karisimbi, and Katana Health Zones in starting reforestation and nursery projects. Youth groups in particular have been enthusiastic about joining, which both augments participation in formal youth club settings and provides increased opportunities for small and large group discussions on SGBV issues… in addition to having a positive and lasting impact on the environment.

The following activities were realized in August and September of 2016:

- A collaborative and mentoring relationship was established between WWF and Ushindi.
- One consultant in environmental protection has been recruited to ensure the training of trainers.
- Sixty young leaders of the clubs were trained as trainers on environmental protection in the health zones of Walikale, Karisimbi and Katana.
- Three pilot agroforestry nurseries were installed in Walikale, Karisimbi and Katana.
- Garden tools (spades, hoes, machetes, strings, rakes, watering cans, etc.) were distributed in the 15 health areas in the three new health zones.
- One hundred and five posters on the multiple uses of trees were distributed to clubs, thanks to our partnership with WWF.
- Five micro plans were developed with local leaders for the implementation of environmental protection activities in the piloted health areas.

Youth club in Walikale learning how to design and manage a nursery (Aug 16)

Breaking ground for the new nursery (Sep 16)

Nurturing seedlings, Walikale (Sep 16)

Tending plants, Karisimbi (Oct 16)

Waste management training, youth club leaders, Karisimbi (Sep 16)

Distribution of gardening equipment, Walikale, (Sep 16)

K. How Ushindi Seeks Cross Sectional Synergy and Leveraging of Program Resources

The recent baseline survey by OSC estimates prevalence rates of SGBV in excess of 30 percent in adults and 60 percent in children, underscoring the significant breadth of this problem in Eastern DRC. IMA is aware of the complex root causes of SGBV, of the significant financial resources needed to address them, and the limited capacity of NGOs (and donors) to meet these challenges. In order to realize a sustainable impact, it is essential for Ushindi and other SGBV projects to seek and engage in *cross-sectional synergy* and *leverage program resources from public and private entities*. To this end, IMA has discussed possibilities and/or engaged in collaborative efforts with the organizations shown in the table below during this reporting period.

Table 17. Organizations contacted for Program Leveraging and Cross-Sectional Synergy

	Organization	Contact Persons	Area of Collaboration
1	***Alpha Mining***	Richard Robinson	In early discussions about collaborating in Walikale in Alpha-Mining health outreach project and services/awareness of SGBV
2	***CARE International***	Michael Landu (COP) Amy O'Toole (dCD)	Met and discussed methodologies of the Tufaidike Wote project in South Kivu to foster reconciliation and shared experience with *noyaux* in promoting gender equity and rights. Agreed on collaborative discussions in future areas of geographic overlap. Participated in USG Awareness Tour and co-managed funding for 16 Days of Activism.

3	***Engage Project***	Carla Bachechi (Proj Dir.) Helen Vesperini (CD)	Established MOU to pilot "Girl Rising" film project in Karisimbi and Goma Health Zones, combining the "Girl Rising" film with Ushindi media messages (starting Jan 2017)
4	***International Medical Corps***	Marie Chantale Gboze (COP) Roch Souabedet (CD)	SBCC outreach (shared best practices/ strategic messages) Currently using former IMC Safe House in Walikale for victims of rape Shared office space in Walikale for other IMA health/development programs
5	***Government of DRC*** ***- Prov. Health Division (DPS)*** ***- Ministry of Justice*** ***- Ministry of Gender*** ***- Ministry of Environment***	Various Provincial and Department Heads	Provided trainers, modules and joint supervision in the following areas; • CPT roll-out and training • Training of medical providers • Training of jurists and evidence gathering • Training in positive masculinity • Start-up of environmental projects
6	***Save the Children***	Sandrine Mabaya (COP)	Shared strategies and methodology for medical care of survivors of sexual violence
7	***Université Libre des Pays des Grands Lacs (ULPGL)***	Rector Dr. Muteho Kasongo	ULPGL provided Ushindi with IRB for previous survey and we are currently establishing an MOU for shared expertise for future areas of operational research
8	***UNICEF***	Nathanael Lumbabo Muzi (GT AMS/GBV)	Met and discussed use and design of PEP kits and strategies for sharing inventories and rotating stock to avoid waste/expired drugs
9	***WFP (UNHAS)***	DRC UNHAS Booking	UNHAS is providing IMA and partners support for Walikale supply and supervision by regular and charter transport flights
10	***World Wildlife Fund***	Gédéon Bakerethi (Chargé de l'Éducation environnementale)	WWF provided IMA with tools, modules, posters and TA for starting '*pépinière* and reforestation projects' for youth clubs and *noyauxs* in three new HZs

L. How Ushindi Promotes Gender Equity and Empowerment

Aside from providing services to survivors of GBV, Ushindi promotes gender equity and empowers women and girls. This report has detailed specific activities in gender empowerment which are summarized below:

1. Socio-economic integration: 7,125 new members joined VLSAs during this reporting period, the majority of whom are women and girls.
2. Justice: 1,078 women received legal aid from ABA clinics for cases ranging from gender discrimination such as land disputes or divorce to violent crimes including rape and assault. Of these complaints, 292 GBV cases were mitigated with settlements to the victims while ABA prepared and brought complaints (largely criminal assault) from 324 women to a legal court setting during this reporting period.

3. Capacity building: IMA and its implementing partners encourage the employment of women in positions of authority in the Ushindi project. Women in the Ushindi project occupy posts such as: Program Manager (PPSSP and ABA), SGBV Advisor (IMA), Finance Officer (IMA), M&E/Research Advisor (IMA), Program Advisor (IMA), and Psychologists (all partners). IMA provides quarterly didactic training sessions in grants management, finance, leadership, M&E, etc. as well as on-site mentoring and capacity building.
4. BCC materials: BCC materials produced by IMA and distributed to its partners place a heavy focus on gender rights and equity.
5. Positive masculinity: IMA has introduced programs in positive masculinity in its youth clubs this semester. Dominant themes are role-modeling and mentoring of boys and young men on the absolutes of gender equity and essential principles of gender rights.
6. Campaigns: IMA and Ushindi partners promoted the 16 Days of Activism this reporting period and promoted through banners, posters, sessions, and conferences the key theme of the 2016 International Women's Day, "Achieving parity between men and women for sustainable development." Ushindi is making active plans to promote this year's 16 Days of Activism theme, "From Peace in the Home to Peace in the World; Make Education Safe (and available) for All".
7. Girl Rising: IMA has entered into a partnership with the ENGAGE project to use Ushindi's network of youth clubs, community *noyaux*, and civil society networks to show the film "Girl Rising," advocating for the education and empowerment of girls.

ENGAGE Country Director, Helen Vesperini, promotes "Girl Rising" during the Ushindi partners meeting (Oct 16)

M.Training

During the reporting period, a series of training programs were undertaken to strengthen technical capacities and skills of service care-givers, and individuals engaged in GBV prevention and women's empowerment. A total number of 2,761 people (44% female, 56% male) were enrolled in the following trainings:

Table 18. Summary of Key Training Activities

Topics	Male	Female	Total
Behavior communication and change in SGBV, for community volunteers	**1066**	**790**	**1856**
VSLA approach and income-generating activities, for reinsertion focal points and *agents de terrain*	152	107	**259**
GBV prevention, peace-building and safe environment, for youth club leaders	95	53	**148**

Psychosocial support for child survivors of SGBV and maltreatment, for child counselors	5	202	**207**
Cognitive processing therapy (CPT) for adults and adolescent survivors of rape	8	5	**13**
Clinical management of sexual violence survivors	104	29	**133**
DRC -GBV laws and judiciary system, for OPJ and Paralegals	129	16	**145**
Total	**1559**	**1202**	**2761**

Training of *noyaux* community leaders, Walikale (Aug 16)

Training of health care workers, Katana (Sep 16)

OPJ (Police) training in evidence gathering Karisimbi, (Aug 16)

Training of psychosocial counselors, Walikale (Aug 16)

V. Challenges/Obstacles/Strategies to Mitigate

1. Insecurity

Insecurity remains the most significant obstacle to project implementation and impact in supported areas.

Challenge: Ongoing insecurity perpetrated by ADF rebels in Ituri Province and Beni Territory has caused significant displacement of the population in areas such as Mutwanga, Komanda, and Lubero and has limited the movement of our staff. In addition, increased episodes of kidnapping of civilians in territories of Rutshuru and Masisi have limited our ability to supervise by road. Insecurity in Mweso HZ and attacks on our vehicle and staff during anti-NGO demonstrations influenced our choice of health zones for this extension period.

Mitigation: IMA and its implementing partners conduct ongoing assessment of the security context and seek clearance before traveling. The majority of supervision visits outside of Goma involve travel by UNHAS or ECHO flights to avoid exposure on roads. Within the HZs, community volunteers and agencies are the primary implementers of SGBV awareness activities and are 'first contacts' to bring victims to services.

A crowd of over 3000 persons marching to the town of Beni to protest 'militia attacks and insecurity in their communities' (Aug 2016)

2. Updating Ushindi Java software for impact evaluation:

Challenge: To support the OSC-led impact evaluation, it was necessary to collect and validate data from over 130 health care facilities and institutions over a five-year period and collate, upload, and analyze. The data needed to be both cleansed and validated, much of it years after the collection process.

Mitigation: IMA hired two external consultants to update Ushindi software and to train over 30 data clerks. Twelve new laptops and 18 obtained from other programs were dedicated to an extensive data mining program, uploading data from across all project sectors (5 years, 79,000 entries). Data validation, collation, and analysis were facilitated by an IMA advisor, a post-graduate student from Emory University.

3. Resistance to changing social norms:

Challenge: Harmful traditional practices perpetuating sexual violence against women are still observed among traditional chiefs and support a "culture of silence or acceptance of SGBV."

Mitigation: IMA and implementing partners reviewed and revised SBCC tools this reporting period and adapted messages encouraging boys and men to see the value of gender equity and realize how positive masculinity is essential in confronting SGBV. Training on tailored themes such as mechanisms of GBV prevention, constitutional law in DRC, and various forms of gender based violence were carried out among a wide range of community stakeholders to increase knowledge of and respect for human rights, gender equality, and women's empowerment.

4. Partial coverage of Ushindi interventions within targeted health zones and lack of GBV interventions in neighboring health zones

Challenge: Certain health zones such as Mulungu, Kalole, and Mumbubano in South Kivu are referring an increased number of rape survivors to proximal Ushindi-assisted health zones to receive PEP treatment. Typically arriving after three days, they are not able to access PEP kits. In such cases, the possibility for an effective treatment is lost and program performance on PEP kit utilization decreases, remaining less than the estimated target of 60 percent.

Mitigation: Ushindi raised BCC messages about PEP kit availability for all survivors in Ushindi supported health centers and increased collaboration with supported health zones to identify remote health centers close to non-supported health zones and maintain sufficient PEP kit availability in these centers.

VI. Environmental Monitoring and Mitigation Plan

Ushindi through its Environmental Monitoring and Mitigation Plan (EMMP), seeks to ensure compliance with 22CFR 21 (Environmental Procedures)[3] by reporting on the potential environmental impact from the range of Intermediate Performance Objectives and Activities it undertakes. Beyond compliance, Ushindi promotes environmental policies and integrated environmental practices into is program activities.

IR1: Increased Access to Quality and Timely Care and Treatment Services

Provision of care and treatment services by Ushindi includes the training and supply of pharmaceutical products (oral medicine and testing of blood and urine). Such activities do not involve giving intravenous or intramuscular drugs or pose a significant risk of transmission of HIV or other blood-borne infections. While Ushindi does not provide direct operational support to health care facilities, it does provide PEP kits for use by victims and survivors of sexual violence. Accordingly, Ushindi recognized it has the shared duty to review, assess, and provide instruction on health care facility management of waste products and associated risks.

During the training sessions and within the modules are instructions for safe lab practices, including handling of blood products as well as management of infectious waste. In addition to didactic sessions and printed modules, Ushindi in collaboration with the DPS (Department Provincial Santé) designed, printed, and distributed posters and wall stickers to be displayed in all health facilities supported by the Ushindi project.

Instructions on management of medical wastes distributed to IPs to post in Ushindi-supported health facilities

IR2: Increased organizational and community capacity to respond to SGBV (BCC) and reintegration of survivors

Reintegration activities for survivors of SGBV include involvement in VLSA, social funds, and microenterprise activities. Such exercises involve dialogue at community levels. Therefore, no adverse environmental impact is expected.

IR3: Increased organizational and community capacity to respond to SGBV

The training and capacity building services offered under Ushindi will mainly involve technical and formative assistance and are not expected to have any environmental impact.

[3] To guarantee adequate environmental oversight and ensure that environmental considerations are integrated into the decision-making process for all USAID-funded projects, programs, and activities, USAID implements Title 22 of the Code of Federal Regulations, Part 216—Environmental Procedures (22 CFR 216). The Code of Federal Regulations (22 CFR 216) assigns USAID responsibility for assessing the foreseeable environmental impacts of the Agency's actions….The CFR states that it is USAID policy to assist host countries with strengthening their capability to evaluate potential environmental effects of proposed projects, and to develop effective environmental programs.. If properly implemented throughout the project cycle, 22 CFR 216 will result in the promotion of environmental policies consistent with USAID's development mandate and environmentally sound activities. http://pdf.usaid.gov/pdf_docs/PDACS130.pdf

IR4: Number of organizations' delivery systems strengthened

Such activities include delivery of products to health facilities and support of youth and women's clubs and are not expected to have any environmental impact.

*In addition, please see section on Environmental Protection Activities undertaken by Ushindi this reporting period in Highlights Section of this report.

VII. Success Stories

A. The Power of "Habits and Haricots"

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SUCCESS STORY

The Power of "Habits and Haricots"

Above: Mme. Rehema & her husband M. Bita attend their VSLA.
Below: M. Bita selling "Habits & Haricots"

Photos IMA World Health

Mme Rehema and M. Bita legalize their marriage before the local state official.

U.S. Agency for International Development
www.usaid.gov

Since 2014, Mme Rehema Munyatangoyi, mother of seven children, has been an active member of the VSLA *Amani Kwetu* in the community Mwangaza (Chefferie of Wamuzimu) in Kitutu health zone.

Mme Rehema is also remarkable in that she succeeded in convincing her husband, M. Bita, to join her VSLA. Working together they were quickly, through their VSAL contributions and investments, able to develop sufficient buying power for their household to initiate two income-generating activities – the first for the sale of clothes (habits) and the second for the sale of beans (haricots).

Perhaps more importantly, however, Mme Rehema reports that, "Our VSLA groups continuing received messages about changing key comportments and how we should be modeling peace between households, families and couples in order to abolish acts of gender violence within our community."

"As we had the privilege to receive these messages as a couple (husband and wife), we decided in July 2016 to set an example by legalizing our marriage after 15 years of cohabitation. Now we can both enjoy our legal marriage rights as they were explained to us through project Ushindi."

Rehema credits project Ushindi, and its continual messages about combatting SGBV and promoting healthy, happy and stable families with helping her husband see new and correct perceptions of marriage, and in encouraging him to legalize their marriage. She concludes, "Thanks to my husband, advise from project Ushindi and from our VSLA I am now a happily and legally-married woman!"

B. The Development Power of VSLAs

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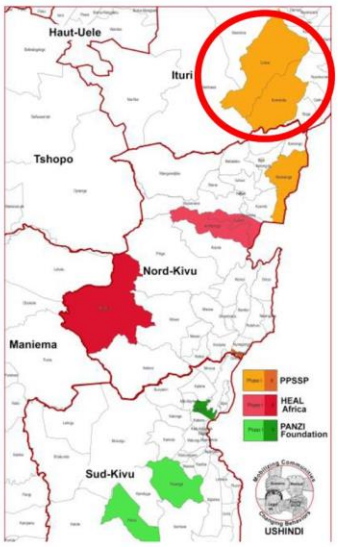
SUCCESS STORY

The Development Power of VSLAs

Photos IMA World Health

Mother "Komanda" poses proudly with her son, who, thanks to her VSLA, is able to have the schooling that she was forced to abandon.



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Call me 'Komanda', since that's the health zone where I was born. My story is sad and glad at the same time. As a teenager, I became pregnant in 2008 from a man who took flight once that he learned of my pregnancy. Left on my own, I had no one to turn to for help during my pregnancy. I suffered greatly, both physically and emotionally, and to the point where I had to abandon my studies in order to support myself.

One day, however, I saw a woman coming towards me. She cornered me and said that she had been observing me and wanted to know about my situation and my problems. I took courage in her kindness and revealed everything that had happened to me. In return, she introduced me to project Ushindi and to the Village Savings and Loan (VSLA) which existed in our community.

I became intrigued with the possibilities that might be offered from a VSLA and joined up. Today I can proudly say that I have completed two cycles of savings with my VSLA and am beginning year three. I have been able, with my savings and loan, to develop my own income generating activity. I am now proudly living a happy life with my son I am proud to say is able to study (and stay) in school thanks to our VSLA.

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In a nearby grouping of villages in the neighboring health zone of Lolwa, a number of teachers lived in a dispersed fashion each one looking out for "Number #1" (in other words on looking out for themselves). That, however, was before project Ushindi began working in their health zone.

After seeing the economic success that Village Savings and Loan Associations were bringing to their communities, the teachers decided to create VSLA of their own. After successfully completing two cycles of contributions and management, they then decided to adopt a distribution/discount of 20,000 Congolese Francs per month and per member with the goal that each member would construct a semi-durable house for themselves. To date, a number of lovely little houses have already been built. This sort of action not only increases their personal socio-economic well-being. It also creates a more resilient community. Helping teachers put down long-term roots into a community contributes to greater stability, greater resiliency and less violence.
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Annex A: FY16 Work Plan Status

Evaluation de mise en oeuvre du Work Plan Ushindi Extension Octobre 2015 - Sept 2016				
PROGRAMS ELEMENTS	**Cible**	**Realisation**	**Progress**	**Commentaires**
Project Activities				
General timeline	**4**	**2**	50%	
Phase down of 3-4 old health zones (HZs) by end of July 2016	1	1	100%	
Start activities in 3 new HZs in USAID priority areas in August 2016	1	1	100%	
End field work by June 2017	1	0	0%	continued activities until June 2017
Project closeout by July 2017	1	0	0%	continued activities until July 2017
0.0 Finalize details of extension phase	9	8	89%	
Identify and hire new staff	1	1	100%	
Finalize procurement for extension phase (cars, computers , medicines, office supplies)	1	1	100%	
Partners meetings				
- Determine new HAs in the selected new health zones	1	1	100%	
- Finalize detailed implementation plan for extension phase	1	1	100%	
- Finalize detailed M&E/research plan for extension phase (impact evaluation, baseline survey)	3	2	67%	Impact evaluation in 3 new health zones by Aug 2017
Sign and start contractors for CPT pilot project and studies	1	1	100%	
Sign new modifications for all partners for extension phase	1	1	100%	
0.1 Inform stakeholders of results of first 6 months of extension phase1	2	2	100%	
Prepare and distribute summary of semi-annual report and extension phase plan	1	1	100%	
Organize presentations of semi-annual report and extension phase plan	1	1	100%	
0.2 Conduct extension phase assessments of existing services (psychosocial, economic, medical and legal needs of survivors), partners, etc.	6	5	83%	
Update IEE risk assessment	1	0.5	50%	Was partially done in accessible HC
Basic needs assessment by health center	1	1	100%	

Compile, analyze and compare progress reports with safe house personnel, implementing partners and beneficiaries	1	0.5	50%	Partial reports copied to IMA
Adapt tools and define methodology of participative survey to evaluate quality of services provided by local staff to meet needs of survivors	1	1	100%	
Conduct a participatory survey to evaluate quality of services provided by local staff, partners and community workers to meet needs of survivors	1	1	100%	
Compile, analyze and share results of participative survey with stakeholders and partners	1	1	100%	
Objective 1. INCREASED ACCESS TO QUALITY AND TIMELY CARE AND TREATMENT SERVICES	51	47	92%	
1.1 Provide psychosocial support to meet needs of survivors of Sexual Violence and GBV	13	10.5	81%	
Revise terms of reference for local staff (technical advisors, child advisors, SGBV management committee staff)	1	1	100%	
Provide psychosocial support for survivors of SGBV and vulnerable people (women, children and men)	1	1	100%	
Ensure child friendly spaces are equipped and operational in all 10 Ushindi bases	1	0.5	50%	phased down following baseline recommendations
Strengthen capacities of temporary foster families	1	0.5	50%	phased down following baseline recommendations
Organize refresher in-service training of counsellors: active listening, trauma counselling etc.	1	0.5	50%	
Reinforce referral system for beneficiaries of psychosocial services	1	1	100%	
Train psychotherapists to provide adequate CPT services to eligible sexual violence survivors in HZ of Walikale, Karisimbi, and Katana	1	1	100%	
Delivering CPT to meet needs of survivors developing PTSD or depression	1	0.5	50%	Started in August 2016, continued activity
Develop referral protocols for identification of CPT cases for each of the 3 IPs.	1	1	100%	achieved in June 2016
Develop tools to assess the level of MH functioning of survivors	1	1	100%	
On-going family mediation in all Ushindi targeted areas	1	1	100%	
Ensure transport for survivors to reinforce referral pathways and access to services within 72 hours in HC and hospital	1	1	100%	
Increase community follow up towards survivors	1	0.5	50%	Activity increased in new health zones

1.2 Provide medical assistance to meet the needs of SGBV survivors	10	10	100%	
At the level of Health Centers				
Evaluate HZ collaboration, adapt and sign protocols with BCZ to reinforce HZ role	1	1	100%	MoU signed between IPs and 10 supported BCZs
Supply medicines and consumables to the health centers, following the national policy (IMA aux IPs)	1	1	100%	
Provide care to survivors of SGBV and vulnerable people	1	1	100%	
Strengthen the management system of medicines and supplies	1	1	100%	Protocol reviewed , PEP kit assembled for individual
Reinforce the referral systems from HCs to regional hospitals and specialty care hospitals for SGBV	1	1	100%	
At the level of General Hospital				
Provide medical care to referred cases of survivors: ob-gyn complications and emergencies; serious injuries	1	1	100%	
Strengthen the medical management system (medicines and supplies) inventory management	1	1	100%	
Reinforce the referral systems from HCs to regional hospitals and specialty care hospitals for SGBV	1	1	100%	
At the level of Tertiary Hospital (HEAL Africa and Panzi)				
Provide surgical repair of fistula, genital prolapse and physical trauma for survivors	1	1	100%	
Reinforce the referral systems from HCs to regional hospitals and specialty care hospitals for SGBV	1	1	100%	
1.3:Provide legal assistance to meet the needs of survivors	17	16.5	97%	
Identify local partner organizations active in SGBV cases to extend legal aid services	1	1	100%	
Provide legal advice on SGBV related acts	1	1	100%	
Provide mediation in case of domestic violence	1	1	100%	
Provide legal assistance before the prosecutor and court system	1	1	100%	
Provide legal counseling on human rights	1	1	100%	
Reinforce awareness of the prevention of SGBV in communities	1	1	100%	
Ensure transport for survivors going to court and staying in transit house	1	0.5	50%	limited resources compared to served people
Produce a methodology guide for all actors on the process of legal aid to SGBV survivors	1	1	100%	
Develop evaluation methodology and tools to evaluate the level of satisfaction of the needs of beneficiaries	1	1	100%	
Organize advocacy towards local authorities to support prevention efforts against SGBV	1	1	100%	
Legal processing of cases, reinforce follow up of cases going through the courts	1	1	100%	paralegals associated

Reinforce referral pathways for beneficiaries from medical to other services	1	1	100%	
Support periodic mobile courts in targeted health zones	1	1	100%	
Conduct regular supervision in 9 targeted legal clinics and subgrantee clinics	1	1	100%	
Identify ownership strategy tools and support local partner organizations active in SGBV cases to extend legal aid services	1	1	100%	
Produce a methodology guide for all actors on the process of legal aid to SGBV survivors	1	1	100%	
Reinforce advocacy towards local authorities for child and wedding registration	1	1	100%	
1.4 Meet the immediate needs of indigent survivors of SGBV in Safe Houses	1	1	100%	
Distribute food and-non-food items (clothing and shelter) to needy survivors of SGBV and vulnerable people	1	1	100%	
1.5 Equip transit houses for front line services (protection, legal, psychosocial, economic) in each HZ	10	9	90%	
Establish safe houses in new HZs	1	1	100%	
Supply safe houses with consumables (food and non-food items) and supplies	1	1	100%	
Complete inventory of contents of transit house	1	1	100%	
Maintain rehabilitation of transit houses	1	1	100%	
Maintain billboards to ensure visibility of the project in safe houses	1	1	100%	
Post the Code of Good Conduct in French and Swahili in the main room of each transit house	1	0	0%	continued advocacy towards Ministry of Social Affairs
Maintain motorbikes and generator and ensure supply of fuel and oil	1	1	100%	
Maintain supplies of consumables in safe house (food, soap, kerosene)	1	1	100%	
Ensure psychosocial support for survivors referred by counsellors	1	1	100%	
Make available legal aid services in the transit house	1	1	100%	
Objective 2. INCREASE ORGANIZATIONAL & COMMUNITY CAPACITY TO RESPOND TO SGBV/FACILITATE RECOVERY OF SURVIVORS	68	59	87%	
2.1 Develop the communities' (*noyaux*) capacity to take ownership of project activities and promote sustainability	4	4	100%	
2.1.1 Noyaux are trained in improved autonomous community management and adopt Standard Operating Procedures (SoP)	4	4	100%	
*Training noyaux on good governance, democratic leadership and elections	1	1	100%	
*Training noyaux on advocacy and communication, BCC techniques	1	1	100%	

*Training noyaux on management techniques and prevention of conflicts	1	1	100%	
*Establishment of noyaux networks in the old ZS	1	1	100%	
2.2. Community leaders respond effectively to the needs of SGBV, model appropriate behaviour and commit to reducing risk factors.	4	4	100%	
Conduct a participatory survey to evaluate progress of change related to BCC messages within targeted communities (baseline)	1	1	100%	taken in account during the achieved impact evaluation
Strengthen in-service training during field supervision with local staff, community volunteers and leaders involved in BCC activities	1	1	100%	
Establish and reinforce youth clubs, child protection mentors	1	1	100%	
Train leaders, health service providers and women's associations on specific SGBV needs of children	1	1	100%	
2.3. Communities respond effectively to the needs of safe environment (youth clubs)	21	17.5	83%	
2.3.1. Integration de l'aspect Protection de l'environnement dans les activites des clubs des jeunes, noyaux communautaires, structures sanitaires, etc.	***5***	***5***	***100%***	
Cartographie et contact avec les Partenaires appuyes par USAID oeuvrant dans la Protection de l'environnement a l'Est/RDC (WCS, WWF,...)	1	1	100%	
Echanges d'expertises et outils BCC avec les intervenants dans le domaine de Protection de l'environnement	1	1	100%	
Recrutement du Consultant en Protection de l'environnement	1	1	100%	
Production des modules sur la plantation d'arbres, la gestion des dechets et autres outils BCC en Protection de l'environnement	1	1	100%	
Selection et Achat des semences agroforestieres/arbres fruitiers et autres intrants dans la	1	1	100%	
2.3.2. Formation des Formateurs des membres des clubs/jeunes et noyaux sur les techniques de protection de l'environnement	***9***	***9***	***100%***	
Techniques d'installation et gestion des pepinieres agroforestieres/arbres fruitiers (Multiplication et plantation des arbres)	1	1	100%	
Identification et selection des beneficiaires de la formation dans les clubs des jeunes et noyaux communautaires	1	1	100%	
Identification et selection des sites pour les activites des Pepinieres agroforestieres/arbres fruitiers dans chaque Aire de sante	1	1	100%	
Organisation des formations sur le tas (Installation et gestion permanente des Pepinieres agroforestieres/arbres fruitiers)	1	1	100%	

Mise en place d'un comite de suivi des pepinieres incluant les Producteurs Multiplcateurs des essences agroforestieres/arbres fruitiers	1	1	100%	
Dotation en intrants (Arrosoires, houes, rateaux, ficelle, mettre ruban, brouette,secateurs, etc.)	1	1	100%	
Plantation d'arbres dans les lieux publics cibles dans chaque aire de sante	1	1	100%	
Distribution des essences agroforestieres/arbres fruitiers aux membres de la communaute	1	1	100%	
Supervisions, suivi - evaluation des activites	1	1	100%	
2.3.3. Techniques de gestion des dechets non biodegradables dans la communaute	***1***	***1***	***100%***	
Identification et selection des IT pour les CS, les Directeurs des ecoles, les membres des noyaux,VSLA, autorites locales, clubs des jeunes, etc.	1	1	100%	
Organisation de l'atelier de recyclage sur la gestion des dechets (Theorie et pratique)	1	0	0%	transferred to BCC activity due to lack of funds
Mise en place d'un microplan pour l'amelioration de la gestion des dechets	1	0	0%	
Suivi d'adoption des bonnes pratiques dans la communaute	1	0	0%	
2.3.4. Activites BCC en Protection de l'environnement	6	2.5	2.5	
Sensibilisations de la communaute sur la gestion des dechets et la plantation des arbres	1	0.5	50%	
Organisation des Focus - groups en faveur des jeunes sur l'importance de la protection de la nature	1	0.5	50%	
Reunions communautaires entre les populations riveraines/Parcs avec les gestionnaires des stations/Parcs sur la prevention des incidents de viol dans la foret	1	0.5	50%	
Organisation des emissions - radio sur l'importance de la protection de l'environnement	1	0.5	50%	
Organisation des campagnes de mass sur la journee internationale de l'arbre et autres journees dans les zones de sante	1	0.5	50%	
Distribution des outils de sensibilisation sur la protection de l'environnement	1	0	0%	
2.3 Health service providers respond effectively to the needs of survivors of SGBV	5	4	80%	
Organize a refresher training on protocols of clinical management of SGBV, management of medical waste	1	1	100%	
Organize in-service trainings during supervision: protocols, quality of care, management of medical waste, medicines management	1	1	100%	
Support in-service training supervisions in HCs and HGRs and follow up on respect for treatment protocols and use of drugs	1	1	100%	
Distribute revised data collection tools to health centers	1	0.5	50%	

Organize a refresher training and follow-up with nurses and doctors on Code of Conduct to prevent SGBV against children	1	0.5	50%	
2.4 Counselors respond effectively to the psychosocial needs of survivors	16	13	81%	
Evaluate and estimate gaps in current mental health services (baseline)	1	1	100%	
Identify and train CPT supervisors (TOT) and psychologists on CPT techniques	1	1	100%	
Identify and train counselors in the 3 new HZs	1	1	100%	
Train counselors from the 3 HZs on CPT (extensive training)	1	0	0%	was reserved to CPT psychologists
Develop improved functionality and symptom tools	1	1	100%	
Design and roll-out of CPT interventions in the 3 new zones	1	1	100%	
Organize monthly technical meetings for staff capacity buildings: trauma counseling, reporting, and follow up of cases	1	1	100%	
Follow up on application of CPT techniques towards trained psychologists / psychotherapists / counselors	1	1	100%	
Provide in-service training for counselors during supervision: psychosocial support for both children and adults, M&E tools	1	1	100%	
Strengthen usage of M&E tools	1	1	100%	
Provide a refresher training for counselors: psychosocial support for both children and adults, data tools	1	1	100%	
Attending local coordination meetings to increase collaboration with other actors working in Ushindi interventions, Ministries, NGOs, UN, etc.	1	1	100%	
Organize trauma debriefing of local staff in safe houses	1	1	100%	
Provide monitoring of clinical outcomes and treatment adherence	1	1	100%	
Develop tools to assess the acceptability of the CPT intervention for approach for counselors and supervisors	1	0	0%	NA
Interpret findings regarding both the effectiveness, feasibility, and acceptability of CPT and the use of this delivery system	1	0	0%	NA
2.5 Legal service providers respond effectively to the needs of survivors	12	10.5	88%	
2.5.1 Provide subgrants to locally based CSOs (with paralegal staff) to strengthen and sustain community mobilization against SGBV in targeted 9 remote rural cities of the Eastern DRC	6	4.5	75%	

Select and support locally based CSOs, paralegals to support and sustain this project objectives through subgrant activities	1	1	100%	
Training / refresher training of key staff of local NGOs on access to justice programming, project management and M&E (feedback on strength and weaknesses of their subgrant applications, and quarterly reports)	1	0	0%	NA
Involving all key stakeholders (noyaux, youth clubs, funded NGOs) in awareness activities (in schools, churches and other public places) on the prevention of SGBV	1	1	100%	
Sensitization by broadcast radio messages on women's and children's rights and access to justice	1	1	100%	
Ensuring effective participation of "local traditional chiefs" and justice sector officials in sensitization and radio broadcasts on women's and children's rights	1	0.5	50%	trained, but continued accompaniment needed
Strengthen the capacity of community leaders in advocacy and lobbying for access to justice for SGBV survivors	1	1	100%	
2.5.2. Provide locally based CSOs with extended capacity in monitoring and evaluation	6	6	100%	
Training by lawyers to CSO paralegals in the management of legal aid clinic and networking with available community responses by laws	1	1	100%	
Refresher training on DQA and data collection and management for 9 legal aid clinic staff, 3 subgrantees M&E field officers	1	1	100%	
Ensuring effective and continuous data collection, analysis and entry in Excel sheets (ABA ROLI and Subgrantees Clinics)	1	1	100%	
Support the organization of monthly meetings of subgrantees at their site level: group review of lessons learned in data compiling, entry and report writing	1	1	100%	
Conduct quarterly joint supervision field mission for data quality audit and control within supported legal aid clinics	1	1	100%	
Semi-annual monitoring workshop to share achievements and lesson learned with key stakeholders (subgrantees, local officials, traditional and community leaders)	1	1	100%	
2.6. Women's organizations and children's groups respond effectively to SGBV (VSLA and youth clubs)	2	2	100%	
Organize awareness campaigns with women's and children's groups to combat SGBV: JIF,JEA,16 Days of Activism against SGBV, International Children's Day, Women's Day, etc.	1	1	100%	
2.7 Youth clubs are trained in improved community engagement and expanded to villages outside of the health centers				

*Training youth clubs in SBCC techniques, life skills	1	1	100%	
2.8. Medical facilities providing services to SGBV survivors offer quality services including medicines, supplies with effective referral and counter-referral pathways	4	4	100%	
Supply medicines and consumables for clinical management of cases of sexual violence to selected health structures (IPs to HZs)	1	1	100%	
Print and distribute patient records to health centers and general hospitals	1	1	100%	
Supervise the correct use of patient files	1	1	100%	
Perform joint supervisions of health facilities with the BCZS (Ministry of Health Central Bureau)	1	1	100%	
Objective 3. IMPROVE THE ABILITY OF COMMUNITIES AND INDIVIDUALS TO LEAD AND PARTICIPATE IN COMMUNITY BASED SOCIAL INTEGRATION	9	8	89%	
3.1: Promote local discussions and conduct awareness campaigns to prevent SGBV and promote positive changes and attitudes using BCC methodologies	3	3	100%	
Adjust strategies and develop BCC tools to prevent SGBV against adults and children	1	1	100%	
Provide technical assistance to local activists (training)	1	1	100%	
Build group capacity for monitoring BCC activities	1	1	100%	
3.2: Create opportunities to engage vulnerable women and men in socio-economic opportunities	2	2	100%	
Improve identification of survivor beneficiaries	1	1	100%	
Provide technical assistance for VSLAs/VSLA networks	1	1	100%	
3.3: Promote community responsibility for social protection and improvement of social and economic capital	4	3	75%	
Initiate and provide technical support to pilot VSLA networks (2 VSLA networks by health zone)	1	1	100%	
ToT of field staff (economic development field officers) on VSLA methods and techniques	1	1	100%	
Joint supervisions of VSLA and micro-project activities (of platforms)	1	0.5	50%	
Monitoring and evaluation of VSLA activities	1	0.5	50%	improved data base and training of collectors needed
Objective 4. STRENGTHEN COMMUNITIES' ABILITY TO PREVENT SGBV	17	12.5	74%	
4.1: Conduct awareness campaigns to reduce tolerance of SGBV and combat rejection of survivors at community level	8	7.75	97%	
Organize awareness campaign with military and police on SGBV, human rights messaging targeting prevention	1	0.75	75%	limited to 7 HZ, not yet started in 3 new health zones

Produce and distribute awareness and educational tools	1	1	100%	
Organization of awareness campaigns in churches, schools, markets, public meeting places	1	1	100%	
Organization of street theater, songs in local languages, radio spots in local languages, posters of key messages in local languages; key messages on SGBV disseminated in local languages, competitions for song, dance, drama, poems, posters, in schools, mosques and churches	1	1	100%	
Raise awareness within the community on human rights, women's rights, children's rights, the law on child protection, sexual violence, family law, and general notions of gender and gender based violence.	1	1	100%	
Organize broadcasts to collect community feedback on SGBV prevention	1	1	100%	
Sign MoU with local radio stations to raise awareness in communities on SGBV prevention and the Ushindi project	1	1	100%	
Participation in interagency meetings	1	1	100%	
4.2: Conduct debates in local forums on the impact of SGBV to promote local responsibility for protection of individuals at risk	3	2.25	75%	
Organize discussion forums on positive masculinity	1	0.75	75%	for a need to be expressed by the full audience in HZ
Prepare, produce and disseminate context-specific advocacy documents	1	0.5	50%	chapter developed during training, disseminate documents
Conduct advocacy sessions	1	1	100%	
4.3 Support women-led groups and children's groups in efforts to involve community leaders in the promotion of the rights of women and children.	3	2.5	83%	
Support women's groups in campaigns for the 16 Days of Activism against SGBV, International Women's Day, etc.	1	1	100%	IP ready to organize/ join the campaigns
Strengthen child/youth capacities to execute BCC activities	1	1	100%	ToT for youth club mentors organized in 3 HZ
Establish community based youth-led complaint mechanisms alongside early warning system, tasked with detection and reporting on sexual violence	1	0.5	50%	needs adapted EWS by health zone
4.4 Community activities promote harmonization of family responsibilities for women, men and children (Integrated in noyaux training)	3	0	0%	
*Parenting skills workshop	1	0	0%	included in SBCC strategies
*Model Family workshop	1	0	0%	included in SBCC strategies

*Parent-Child Club Focus Groups	1	0	0%	included in SBCC strategies
5. ADMINISTRATION, MONITORING AND EVALUATION	23	22.5	98%	
5.1 ADMINSTRATION	12	12	100%	
Organize internal board meeting with Ushindi Goma management staff	1	1	100%	
Organize quarterly partners coordination meetings	1	1	100%	
Ensure capacity building of staff is in place: trainings, meetings with SGBV partners	1	1	100%	
Participation at interagency meetings: assessment of security, bilateral collaboration with other partners	1	1	100%	
Participating in social protection meetings with USAID partners in Kinshasa/Eastern DRC	1	1	100%	
Monthly meetings with IPs and TPs for strategic planning	1	1	100%	
Field supervisions by IMA World Health management staff to evaluate the execution of operational and strategic plan, and project management	1	1	100%	
Strengthen logistics: maintenance of vehicles, generators, furniture, network, communication equipment, offices supplies, motorcycles, etc.	1	1	100%	
Conduct semi-annual inventory within HZs	1	1	100%	
Organize an internal finance audit: in-service training of staff, budgets and procedures control	1	1	100%	
Preparing external audit: financial	1	1	100%	
Produce monthly paragraph reports (as required)	1	1	100%	
5.1 M&E/Research	11	10.5	95%	
Conduct and analyze baseline survey in the 3 new HZs (external consultant)	1	1	100%	
Improve database, do analyses and share outputs with key stakeholders (Impact evaluation, baseline survey, routine DQA)	1	1	100%	
Integrate impact evaluation and baseline survey recommendations, lessons learned, and best practices	1	1	100%	
Conduct a participatory baseline survey to evaluate progress of change among targeted beneficiaries and quality of services	1	1	100%	
Ensure understanding and correct use of data collection tools at every level	1	1	100%	
Refresher training on M&E for field staff	1	1	100%	
Organize a quarterly joint supervision with TPs, IPs and BCZS to evaluate the effectiveness and efficiency of the project	1	1	100%	

Organize an internal DQA with Ushindi partners	1	0.5	50%	HA & ABA visited, will be extended to PPSSP & Panzi
Produce semi-annual and annual reports	1	1	100%	
Formation sur les procedures financieres USAID	1	1	100%	
Transmission de rapports paragraphe, narratif, statistique, GTAMS et le BACK UP	1	1	100%	
Comment: The Ushindi FY16 annual work plan was completely executed unless some activities like organizing group discussion with local authorities and community members on the impact of SGBV to promote local responsibility for protection of individuals at risk. IMA will review the advocacy adapted techniques and intensify refresher training for community mobilizers and youth clubs to intensify organization of group discussion with different audiences.				

Annex B: FY17 Work Plan Planned

Work Plan Ushindi (FY17)

PROGRAM ELEMENTS	FY 2017				Actor	Technical Partner
Project Activities	Q1	Q2	Q3	Q4		
General timeline						
Final detailed preparations (see below 0.0)					IMA	All
Phase out of 3-4 old Health Zones (HZs) by end of July					IMA	All
Start new HZs in USAID priority areas in August	X	X	X		IMA	All
Reduce support to old HZs in February 2017		X	X		IMA	All
End field work by May 2017			X		IMA	All
Project closeout				X	IMA	All
0.0 Finalize details of extension phase						
Identify and hire new staff					IMA	All
Partners meetings					IMA	All
- Determine new HZs and HAs					IMA	All
- Finalize detailed implementation plan for extension phase					IMA	All
- Finalize detailed M&E/research plan for extension phase					IMA	All
- Finalize budgets for extension phase					IMA	All
- Finalize budgets for extension phase					IMA	All
Solicit contractors and negotiate for CPT pilot project and studies					IMA	
Prepare new modifications for all partners for extension phase					IMA	
0.1 Inform stakeholders of results of first 5 years and extension phase						

Prepare and distribute summary of 5 year report and extension phase plan					IMA	
Organize presentations of 5 year report and extension phase plan					IMA	All
0.2 Conduct extension phase assessments of existing services (psychosocial, economic, medical and legal needs of survivors), partners, etc.						
Update IEE risk assessment					IMA	
Compile, analyze and compare progress reports with safe house personnel, implementing partners and beneficiaries					IMA/IPs	All
Adapt tools and define methodology of participative survey to evaluate quality of services provided by local staff to meet needs of survivors					IMA	All
Conduct a participatory survey to evaluate quality of services provided by local staff to meet needs of survivors					IMA/IPs	
Compile, analyze and share results of participative survey with stakeholders and partners					IMA	All
Objective 1. INCREASED ACCESS TO QUALITY AND TIMELY CARE AND TREATMENT SERVICES						
1.1 Provide psychosocial support to meet needs of survivors of sexual violence and GBV						
Revise terms of reference for local staff (technical advisors, child advisors, SGBV management committee staff)					IMA/IPs	All
Provide psychosocial support for survivors of SGBV and vulnerable people (women, children and men)	X	X	X		IPs	IMA/SC
Ensure child friendly spaces are equipped and operational in all 6 Ushindi bases					IPs	IMA/SC
Strengthen capacities of temporary foster families					IPs	IMA/SC
Organize refresher in-service training of counselors: active listening, trauma counselling etc.	X				IPs	IMA/SC
Reinforce referral system for beneficiaries of psychosocial services					IMA/IPs	IMA/SC
On-going family mediation in all Ushindi targeted areas	X	X	X		IPs/ABA	
Ensure transport for survivors to reinforce referral pathways and access to services within 72 hours in HC and hospital	X	X	X		IPs	
Increase community follow up towards survivors	X	X	X		IMA/IPs	All
1.2 Provide medical assistance to meet the needs of SGBV survivors						

At the level of Health Centers						
Evaluate HZ collaboration, adapt and sign protocols with BCZ to reinforce HZ role					IMA/IPs	
Supply medicines and consumables to the health centers, following the national policy					IMA/IP/HZ	
Provide care to survivors of SGBV and vulnerable people	X	X	X		HZs	IPs
Strengthen the management system of medicines and supplies					IMA/IPs	
Reinforce the referral systems from HCs to regional hospitals and specialty care hospitals for SGBV			X		IP/HZ	IMA
At the level of General Hospital						
Provide medical care to referred cases of survivors: ob-gyn complications and emergencies; serious injuries	X	X	X		HZs	IPs
Strengthen the medical management system (medicines and supplies) inventory management					IMA/IP/HZ	
Reinforce the referral systems from HCs to regional hospitals and specialty care hospitals for SGBV			X		IP/HZ	IMA
At the level of Tertiary Hospital (HEAL Africa and Panzi)						
Provide surgical repair of fistula, genital prolapse and physical trauma for survivors	X	X	X		IPs	
Reinforce the referral systems from HCs to regional hospitals and specialty care hospitals for SGBV			X		IP/HZ	IMA
1.3:Provide legal assistance to meet the needs of survivors						
Identify and support local partner organizations active in SGBV cases to extend legal aid services	X	X	X		ABA	IMA/IP
Provide legal advice on SGBV related acts	X	X	X		ABA	IP
Provide mediation in case of domestic violence	X	X	X		ABA	IP
Provide legal assistance before the prosecutor and court system	X	X	X		ABA	IP
Provide legal counseling on human rights	X	X	X		ABA	IP
Reinforce awareness of the prevention of SGBV in communities	X	X	X		ABA	IP
Ensure transport for survivors going to court and staying in transit house	X	X	X		ABA	IP
Produce a methodology guide for all actors on the process of legal aid to SGBV survivors					ABA	IP

Develop evaluation methodology and tools to evaluate the level of satisfaction of the needs of beneficiaries					ABA	IP
Organize advocacy towards local authorities to support prevention efforts against SGBV	X	X	X		ABA	IP
Legal processing of cases, reinforce follow up of cases going through the courts	X	X	X		ABA	IP
Reinforce referral pathways for beneficiaries from medical to others services	X	X	X		ABA	IP
Support periodic mobile courts in targeted health zones		X			ABA	IP
Conduct regular supervision in 6 targeted legal clinics and subgrantee clinics	X	X	X		ABA	IP
Identify ownership strategy tools and support local partner organizations active in SGBV cases to extend legal aid services	X	X	X		ABA	
Produce a methodology guide for all actors on the process of legal aid to SGBV survivors					ABA	
Reinforce advocacy towards local authorities for child and wedding registration	X	X	X		ABA	IP
1.4 Meet the immediate needs of indigent survivors of SGBV in Safe Houses						
Distribute food and non-food items (clothing and shelter) to needy survivors of SGBV and vulnerable people	X	X	X		IPs	
1.5 Equip transit houses for front line services (protection, legal, psychosocial, economic) in each HZ						
Supply safe houses with consumables (food and non-food items) and supplies	X	X	X		IPs	
Complete inventory of contents of transit house			X		IPs	
Establish safe houses in new HZs					IMA/IP	
Maintain rehabilitation of transit houses					IPs	
Maintain billboards to ensure visibility of the project in safe houses					IPs	
Post the Code of Good Conduct in French and Swahili in the main room of each transit house					IPs	
Maintain motorbikes and generator and ensure supply of fuel and oil	X	X	X		IPs	
Maintain supplies of consumables in safe houses (food, soap, kerosene)	X	X	X		IPs	
Ensure psychosocial support for survivors referred by counselors	X	X	X		IPs	
Make available legal aid services in the transit house	X	X	X		IPs	ABA
Objective 2. INCREASE ORGANIZATIONAL & COMMUNITY CAPACITY TO RESPOND TO SGBV/FACILITATE RECOVERY OF SURVIVORS						

2.1 Develop the communities' (noyaux) capacity to take ownership of project activities and promote sustainability						
2.1.1 Noyaux are trained in improved autonomous community management and adopt Standard Operating Procedures (SoP)						
*Training noyaux on good governance, democratic leadership and elections	X	X	X		IPs	
*Training noyaux on advocacy and communication, BCC techniques	X	X	X		IPs	
*Training noyaux on management techniques and prevention of conflicts	X	X	X		IPs	
*Establishment of noyaux networks					IPs	IMA
2.1.2 Noyaux develop micro-plans for community actions						
*Training on identification, choice and management of community micro-projects					IPs	
*Training noyaux/leader on financial management					IPs	IMA
2.2 Community leaders respond effectively to the needs of SGBV, model appropriate behavior and commit to reducing risk factors						
Conduct a participatory survey to evaluate progress change related to BCC messages within targeted communities					IPs	
Strengthen in-service training during field supervision with local staff, community volunteers and leaders involved in BCC activities	X	X	X		IPs	
Reinforce youth clubs, child protection mentors			X		IPs	
Train leaders, health service providers and women's associations on specific SGBV needs of children			X		IPs	
2.3 Health service providers respond effectively to the needs of survivors of SGBV						
Organize a refresher training on protocols of clinical management of SGBV, management of medical waste					IPs	BCZ
Organize in-service trainings during supervision: protocols, quality of care, management of medical waste, medicines management			X		IPs	BCZ
Support in-service training supervisions in HCs and HGRs and follow up on respect for treatment protocols and use of drugs.	X	X			IPs	BCZ
Distribute revised data collection tools to health centers					IPs	IMA

Organize a refresher training and follow-up with nurses and doctors on code of conducts to prevent SGBV against children			X		IPs	SC
2.4 Counsellors respond effectively to the psychosocial needs of survivors						
Train and supervise roving counselors for CPT (pilot)	X	X			IPs	Contractor
Develop improved functionality and symptom tools						
Provide a refresher training for counselors: psychosocial support for both children and adults, data tools			X		IPs	IMA
Provide in service training for counselors during supervision: psychosocial support for both children and adults, M&E tools	X	X	X		IPs	
Organize monthly technical meetings for staff capacity building: trauma counselling, reporting, and follow up of cases	X	X	X		IPs	
Organize training supervisions in safe houses by IPs and TPs	X	X	X		IPs	
Follow up on application of training of counselors	X	X	X		IPs	IMA
Attending local coordination meetings to increase collaboration with other actors working in Ushindi interventions, Ministries, NGOs, UN, etc.	X	X	X		IPs	
Organize trauma debriefing of local staff in safe houses	X	X	X		IPs	
Strengthen usage of M&E tools	X	X	X		IPs	IMA
2.5 Legal service providers respond effectively to the needs of survivors						
2.5.1 Provide subgrants to locally based CSOs (with paralegal staff) to strengthen and sustain community mobilization against SGBV Eastern DRC						
Select locally based CSOs to support and sustain this project objectives through subgrant activities					ABA	
Training of key staff of local NGOs on access to justice programming, project management and M&E (feedback on strengths and weaknesses of their subgrant applications, and quarterly reports)	X	X	X		ABA	CSO
Involving all key stakeholders (noyaux, youth clubs, funded NGOs) in awareness activities (in schools, churches and other public places) on the prevention of SGBV	X	X	X		ABA	CSO/IP
Sensitization by broadcast radio messages on women's and children's rights, and access to justice	X	X	X		ABA	CSO/IP

Ensuring effective participation of "local traditional chiefs" and Justice sector officials in sensitization and radio broadcasts on women's and children's rights	X	X	X		ABA	CSO/IP
Strengthen the capacity of community leaders in advocacy and lobbying for access to justice for SGBV survivors	X	X	X		ABA	CSO/IP
2.2. Provide locally based CSOs with extended capacity in monitoring and evaluation						
Training by lawyers to CSO paralegals in the management of legal aid clinics and networking with available community responses by laws					ABA	CSO
Refresher training on DQA, and data collection and management for 6 legal aid clinics' staffs, 10 subgrantees M&E field officers	X				ABA	CSO
Ensuring effective and continuous data collection, analysis and entry in Excel sheets (ABA ROLI and Subgrantees Clinics)	X	X			ABA	CSO
Support the organization of monthly meetings of subgrantees at their site level: group review of lessons learned in data compiling, entry and report writing	X	X	X		ABA	CSO
Conduct quarterly joint supervision field mission for data quality audit and control within supported legal aid clinics	X	X	X		ABA	CSO
Semi-annual monitoring workshop to share achievements and lesson learned with key stakeholders (subgrantees, local officials, traditional and community leaders)		X			ABA	CSO
2.5. Women's organizations and children's groups respond effectively to SGBV						
Organize awareness campaigns with women's and children's groups to combat SGBV: JIF, JEA, 16 Days of Activism against SGBV, International Children's Day, Women's Day, etc.	X	X	X		IP	
Youth clubs are trained in improved community engagement and expanded to villages outside of the health centers						
*Training youth clubs in SBCC techniques, life skills					IP	
*Training micro project for community good (including environment protection)					IP	
*Training youth clubs on peace building (Jeunes Batisseur de la Paix)					IP	
*Micro project for community good (including environment protection)	X	X	X		IP	
2.6. Medical facilities providing services to SGBV survivors offer quality services including medicines and supplies, with effective referral and counter-referral pathways.						

Supply medicines and consumables for clinical management of cases of sexual violence to selected health facilities	X	X	X		IMA	IP
Print and distribute patient records to health centers and general hospitals	X	X	X		IPs	BCZ
Supervise the correct use of patient files	X	X	X		IPs	BCZ
Perform joint supervisions of health facilities with the BCZS (Ministry of Health Central Bureau)	X	X	X		IPs	BCZ
Objective 3. IMPROVE THE ABILITY OF COMMUNITIES AND INDIVIDUALS TO LEAD AND PARTICIPATE IN COMMUNITY BASED SOCIAL INTEGRATION						
3.1: Promote local discussions and conduct awareness campaigns to prevent SGBV and promote positive changes and attitudes using BCC methodologies						
Adjust strategies and develop BCC tools to prevent SGBV against adults and children					IPs	
Provide technical assistance to local activists	X	X	X		IPs	
Refresher training of community educators: BCC techniques & strategies, theater and creative arts for the development of youth					IPs	
Build group capacity for monitoring BCC activities	X	X	X		IPs	
3.2: Create opportunities to engage vulnerable women and men in socio-economic opportunities						
Improve identification of survivor beneficiaries					IPs	IMA
Implement pilot project for providing assistance to SGBV survivors into VSLAs	X	X	X		IPs	IMA
Provide technical assistance for VSLAs	X	X	X		IPs	
3.3: Promote community responsibility for social protection and improvement of social and economic capital						
Develop and establish pilot project for creating VSLA platforms	X	X	X		IPs	IMA
ToT of field staff (economic development field officers) on VSLA methods and techniques					IPs	IMA
Joint supervisions of VSLA and micro-project activities (of platforms)	X	X	X		IPs	IMA
Monitoring and evaluation of VSLA activities	X	X	X		IPs	
Objective 4. STRENGTHEN COMMUNITIES' ABILITY TO PREVENT SGBV						
4.1: Conduct awareness campaigns to reduce tolerance of SGBV and combat rejection of surviors at community level.						

10 Lessons for Life printed on children's materials; soccer balls, pens for school					IMA	All
Organize awareness campaign with military and police on SGBV, human rights messaging targeting prevention	X		X		IPs	
Produce and distribute awareness and educational tools					IPs	
Organization of awareness campaigns in churches, schools, markets, public meeting places	X	X	X		IPs	
Organization of street theater, songs in local languages, radio spots in local languages, posters of key messages in local languages; key messages on SGBV disseminated in local languages, competitions for song, dance, drama, poems, posters, in schools, mosques and churches	X	X	X		IPs	
Raise awareness within the community on human rights, women's rights, children's rights, the law on child protection, sexual violence, family law, and general notions of gender and gender based violence.	X	X	X		IPs	
Organize broadcasts to collect community feedback on SGBV prevention	X	X	X		IPs	
Sign MoU with local radio stations to raise awareness in communities on SGBV prevention and the Ushindi project					IPs	
Participation in interagency meetings	X	X	X		IPs	
4.2: Conduct debates in local forums on the impact of SGBV to promote local responsibility for protection of individuals at risk						
Organize discussion forums on positive masculinity	X	X	X		IPs	
Prepare, produce and disseminate context-specific advocacy documents					IPs	IMA
Conduct advocacy sessions	X	X	X		IPs	
4.3 Support women-led groups and children's groups in efforts to involve community leaders in the promotion of the rights of women and children.						
Support women's groups in campaigns for the 16 Days of Activism against SGBV, International Women's Day, etc.	X	X	X		IPs	
Strengthen child capacities to execute BCC activities	X	X	X		IPs	
Establish community based youth-led complaint mechanisms alongside early warning system, tasked with detection and reporting on sexual violence			X		IPs	
4.4 Community activities promote harmonization of family responsibilities for women, men and children						

*Parenting skills workshop					IPs	
*Model Family workshop					IPs	
*Parent-Child Club Focus Groups	X	X	X		IPs	
5. ADMINISTRATION, MONITORING AND EVALUATION						
5.1 ADMINSTRATION						
Organize internal board meeting with Ushindi Goma management staff					IMA	All
Organize quarterly partners coordination meetings	X	X	X		IMA	All
Ensure capacity building of staff is in place: trainings, meetings with SGBV partners	X	X			IMA	All
Participation at interagency meetings: assessment of security, bilateral collaboration with other partners	X	X	X	X	IMA	All
Participating in social protection meetings with USAID's partners in Kinshasa	X	X	X	X	IMA	
Monthly meetings with IPs and TPs for strategic planning	X	X	X	X	IMA	All
Field supervisions by IMA World Health management staff to evaluate the execution of operational and strategic plan and project management	X	X	X		IMA	All
Strengthen logistics: maintenance of vehicles, generators, furniture, network, communication equipment, offices supplies , motorcycles, etc.					IMA	
Conduct semi-annual inventory within HZs		X	X		IMA	IPs
Organize an internal finance audit: in service training of staff , budgets and procedures control	X				IMA	All
Preparing external audit: financial					IMA	IPs
Produce monthly updates (as required)	X	X	X		IMA	IP/TP/IMA
Report back, preparation of year 4 plan and budget					IMA	All
5.1 M&E/Research						
Develop baseline survey					IMA	All
Perform and analyze baseline					IMA	Contractor
Improve database and do analyses	X	X	X		IMA	
Conduct a participatory survey to evaluate progress of change among targeted beneficiaries and quality of services			X		IPs	

Ensure understanding and correct use of data collection tools at every level	X	X	X		IPs	IMA
Refresher training on M&E for field staff			X		IMA	All
Organize a quarterly joint supervision with TPs, IPs, and BCZS to evaluate the effectiveness and efficiency of the project	X	X	X		IMA	All
Organize an internal DQA with Ushindi partners	X	X	X		IMA	All
Produce semi-annual and annual reports	X		X	X	IMA	All

Annex C: FY17 Budget

Cooperative Agreement No. AID-623-A-10-00012
OVERCOMING SEXUAL AND GENDER BASED VIOLENCE (SGBC) in EASTERN CONGO / Ushindi
Interchurch Medical Assistance, Inc. (dba IMA World Health)
Budget (October 1, 2016 - July 30, 2017)

Currency :USD

				FY17 10/01/16 -07/31/17		
				Base	Months	Total Costs
A. Salaries				%		
Headquarters						
Program Officer				10%	10	
Financial Analyst				20%	10	
Senior Technical Advisor				10%	10	
Subtotal Headquarter Salaries						**$ 33,750**
In-Country/Kinshasa						
Program Officer	Evelyn Howatt			10%	10	
Finance Officer	Nancy Allan			10%	10	
Subtotal						
In-Country/Goma						
Chief of Party	William Clemmer			100%	10	
ME/Research Advisor	Manka Banda			25%	10	
Subtotal						
In-Country/Goma - National Staff						
Program Manager/NGO Coordinator	Joseph Ciza			100%	10	
GBV/SBCC Advisor	Alice Mudekereza			100%	10	
ME Officer	Patrick Bahati			100%	10	
Administrator Charge des Finances	Alfred Sefu			100%	10	
Socio-economic coordinator	Cherubin Sadiki			100%	10	
Finance Officer	Michaelle-Diane			100%	10	
Operations Manager	Eric Binwa			100%	10	
Procurement Assistant	Djibril Muhambikwa			100%	10	
Driver	Claude Latigo			100%	10	
Subtotal						
Subtotal In Country						**$ 248,981**
B. Fringe Benefits				**Base**		

Headquarters (including in-country ex-pat staff)						$ 45,107
DRC National Staff						$ 108,610
Total Fringe Benefits						**$ 153,717**
C. Allowances						
Kinshasa Staff						$ 4,063
Goma Staff						$ 35,938
Total Allowances						**$ 40,000**
D. Consultant		**Rate**		**# days**		
STTA for GBV				120		$ 12,000
IMA Senior Technical Advisor				30		$ 19,470
Local consultants				40		$ 3,000
Total Consultants						**$ 34,470**
E. Travel		**Rate**		**# trips/days**		
International Travel						
Technical Assistance Support Supervision-Headquarters						
Airfare (USA to Goma, DRC)		$ 2,500	/trip	1		$ 2,500
Lodging		$ 90	/day	15		$ 1,350
M&IE		$ 79	/day	15		$ 1,185
Other Travel expenses (Visas, transportation		$ 25	/day	15		$ 375
Participation in workshops, conferences, HQ visits, etc.						
Airfare (Goma, DRC to X)		$ 2,500	/trip	1		$ 2,500
Lodging		$ 120	/day	7		$ 840
M&IE		$ 80	/day	7		$ 560
Other Travel expenses		$ 25	/day	7		$ 175
Subtotal International Travel						**$ 9,485**
In-Country (DRC) Travel - COP Team						
Airfare/Transportation		$ 400	/trip	40		$ 16,000
Lodging		$ 50	/day	300		$ 15,000
M&IE		$ 30	/day	300		$ 9,000
Other Travel expenses		$ 25	/day	300		$ 7,500
Subtotal Domestic Travel						**$ 47,500**
Total Travel						**$ 56,985**

F. Equipment		Unit Cost		Qty		
Vehicles - Toyota	Landcruiser	$ 45,000	unit			
Motorcycles	For IPs, 1/HZ	$ 3,000	unit	1		$ 3,000
Sat phones/Thuraya	For staff traveling	$ 1,000	unit			
Laptops	IP and Goma Staff	$ 750	unit	2		$ 1,500
Software	SPSS, database	$ 1,500	lump			
Printers	For IPs, 1/HZ	$ 500	unit	2		$ 1,000
Generator	Office	$ 3,000	unit			$ -
Office furniture	new staff	$ 1,000	lump	2		$ 2,000
Total Equipment						**$ 7,500**
G. Supplies		**Unit Cost**				
PEP Kits		$ 40	/survivor	1200		$ 48,000
BCC Supplies		$ 12,000	year	50%	1	$ 6,000
Total Supplies						**$ 54,000**
H. Contractual Costs				**%**		
CPT Pilot (JHU or UWASH or HAI)		$ 142,000	/year	20%		$ 28,400
Research/KABP (Dr Lynn Lawry)		$ 97,000	/lump	50%		$ 48,500
American Bar Association		$ 440,000	/year	67%		$ 294,800
Heal Africa		$ 550,000	/year	67%		$ 368,500
Panzi Hospital		$ 550,000	/year	67%		$ 368,500
PPSSP (Program for Promotion of Primary Health Care)		$ 550,000	/year	67%		$ 368,500
Total Contractual Costs						**$1,477,200**
I. Other Direct Costs						
HQ						
Bank Fees		$ 1,200	/year	100%	10	$ 1,000
Audit Fees - HQ		$ 5,000	/year	100%	10	$ 4,167
Meeting Registration/Conferences		$ 1,800	/year	100%	10	$ 1,800
Shipping Fees		$ 1,000	/container	100%		$ 1,000
Kinshasa						
Office Expenses/Supplies		$ 250	/year	100%	10	$ 208
Bank Fees		$ 1,200	/year	100%	10	$ 1,000
Communication - Phone		$ 75	/mo	1	10	$ 750
Communication - Internet		$ 75	/mo	1	10	$ 750
Kinshasa Office Rent		$ 208	/mo/13.67m²/person	20	1	$ 4,160
Goma Office & Annex Costs						

Bank charges/fees		$ 500	/month	1	10	$ 5,000
Generator Fuel		$ 160	/month	1	10	$ 1,600
Goma Office & Annex Rent		$ 2,600	/month	1	10	$ 26,000
Internet in the office		$ 1,000	/month	1	10	$ 10,000
Codan/Internet Units for senior staff/traveling, etc..		$ 800	/month	1	10	$ 8,000
Office Expenses/Supplies		$ 1,300	/month	1	10	$ 13,000
Phone Cards: 13 people		$ 500	/month	1	10	$ 5,000
Security guards to COP Office		$ 600	/month	1	10	$ 6,000
Temporary employees for office cleaners		$ 300	/month	1	10	$ 3,000
Temporary drivers		$ 100	/month	1	10	$ 1,000
Vehicle Operational & Maintenance cost		$ 2,800	/month	1	10	$ 28,000
Other Costs						
CPT pilot - IMA costs		$ 25,000	/pilot	50%	1	$ 12,500
GBV Survey IMA costs		$ 25,000	/survey	25%	1	$ 6,250
ME Data Bank Mining-IMA costs		$ 15,000	/project	20%	1	$ 3,000
COP team capacity development (registration fees, etc)		$ 74	/month	10	1	$ 737
Branding		$ 500	/year	100%	1	$ 500
Translation		$ 500	/year	100%	1	$ 500
Legal Fees		$ 800	/year	100%	1	$ 800
Meetings and training sessions for IPs		$ 600	/month	100%	10	$ 6,000
Printed tools for SBCC and VSLA		$ 6,000	/tools	100%	1	$ 6,000
Shipping/Medicines to HZs		$ 1,000	/year	100%	1	$ 1,000
Transport of HZ equipment to Goma		$ 1,000	/year	100%	1	$ 1,000
Total Other Direct Costs						**$ 159,722**
Reserve NCE/Mobile Court/Campaign/SBCC						$ 200,000
J.Total Direct Costs						**$2,466,325**
Indirect Costs			**Base**			
		11.61%		2,094,625		$ 243,186
K. Total Indirect Costs						**$ 243,186**
L. TOTAL COSTS						**$2,709,511**

Annex D: FY16 Trafficking Data

Répartition des cas selon l'incident rapporté/déclaré	TOTAL ANNUEL : Oct 2015 - Sept 2016							Observation
	Enfants			Adultes			Tot. G	
	M	F	S/tot	M	F	S/tot		
Total cas de Traffic d'être humain (sous total de A, B et C)								
Cas d'enlevèment / kidnapping / deportation	0	4	4	8	5	13	17	*La ZS Lubero est la plus touchee avec 9 cas d'enlevement, Komanda avec 7 survenus au mois d'avril par les milices du FRPI et un cas a Alimbongo*
Force d'etre esclavage sexuel	0	5	5	0	4	4	9	*8 cas dans la ZS de Lubero*
Cass de prostitution forcée	0	0	0	0	0	0	0	
Force de travailler dans une mine	0	0	0	0	0	0	0	
Force de travailler dans une plantation	0	0	0	0	0	0	0	
Enrôlement forcé dans un groupe arme/ forcées armées régulières	0	0	0	0	0	0	0	
Force de travailler dans un bar ou bistro	0	0	0	0	0	0	0	
Forcée dans le proxénétisme	0	0	0	0	0	0	0	
Forcée d'être mariée pour payer la dette du mari/ parents / frères	0	1	1	0	0	0	1	*Ce cas est survenu dans la ZS Mwenga*
Force de payer des taxes illégales	0	0	0	0	0	0	0	
Force d'avoir des rapports sexuel pour accès aux services sociaux existants	0	0	0	0	0	0	0	
Force de prendre part a des rites d'initiation/ pratiques traditionnelles	0	0	0	0	0	0	0	
TOTAL							**27**	

*Data collected on sex trafficking in FY 16 is minimal as information was not a part of previous project collection tools or agreed project indicators.
Please see Annex E (FY17 outil de collecte) with specific inquiries on sex trafficking; currently being disseminated/used in new health zones for FY17 reporting.

Annex E: FY17 Revised Reporting Tool Ushindi

[See following]